California State Auditor

BUREAU OF STATE AUDITS

Workers' Compensation Fraud:

Detection and Prevention Efforts Are Poorly Planned and Lack Accountability

April 2004
2002-018

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CALIFORNIA STATE AUDITOR

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April 29, 2004 2002-018

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As required by Chapter 6, Statutes of 2002, the Bureau of State Audits presents its audit report concerning the effectiveness of the Fraud Assessment Commission (fraud commission), the Fraud Division, the Department of Insurance, the Department of Industrial Relations (Industrial Relations), and local law enforcement agencies in identifying, investigating, and prosecuting workers' compensation fraud and employers' willful failure to provide workers' compensation benefits for their employees.

This report concludes that although employers are assessed annually to pay for efforts to reduce fraud in the workers' compensation system—an amount that has averaged about $30 million per year for the past five years—the fraud commission and the insurance commissioner have not taken adequate steps to measure fraud in the system, develop a strategy to reduce it, or ensure that the fraud assessment funds are distributed to most effectively investigate and prosecute workers' compensation fraud. Because the Department of Insurance's Fraud Division (fraud division) does not conduct adequate strategic planning, it does not allocate a sufficient amount of its resources to meet its noninvestigative responsibilities, including those relating to researching and reporting on the level and affects of fraud in the system and monitoring county district attorneys' compliance with the requirements of the workers' compensation antifraud program and insurers' compliance with suspected fraud-reporting requirements. Improvement is needed in sharing information between Industrial Relations and the fraud division to identify potential workers' compensation fraud. Industrial Relations has not implemented three statutory programs intended to identify employers who fail to provide workers' compensation insurance or benefits for their employees; implement a protocol for reporting medical provider fraud; and to annually warn employers, claims adjusters and administrators, medical providers, and attorneys who participate in the system about the legal risks associated with committing workers' compensation fraud.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

CONTENTS

Summary 1

Introduction 13

Chapter 1

Workers' Compensation Antifraud Efforts Lack Adequate Planning and Coordination, and Funding Is Not Determined Using Established Priorities 25

Recommendations 53

Chapter 2

Lacking Adequate Strategic Planning, the Fraud Division Has Not Met All Its Responsibilities for the Workers' Compensation Antifraud Program 57

Recommendations 80

Chapter 3

Efforts to Detect and Prevent Workers' Compensation Fraud Are Inadequate and Lack Cooperation Between Agencies 83

Recommendations 102

Appendix A

Recommendations From Various Entities for Antifraud Grants to District Attorneys 107

Appendix B

The Fraud Division's Referral Form for Suspected Fraudulent Claims 109

Responses to the Audit

Department of Insurance 113

California State Auditor's Comments on the Response From the Department of Insurance 131

Fraud Assessment Commission 135

California State Auditor's Comments on the Response From the Fraud Assessment Commission 143

Labor and Workforce Development Agency 149

California State Auditor's Comments on the Response From the Labor and Workforce Development Agency 155

SUMMARY

Audit Highlights . . .

Our review of the State's program to reduce workers' compensation fraud revealed that:

- ☑ *Although employers are assessed annually to pay for efforts to reduce fraud in the workers' compensation system—an amount that has averaged about $30 million per year for the past five years—the Fraud Assessment Commission (fraud commission) and the insurance commissioner have not taken steps to measure fraud in the system or develop a statewide strategy to reduce it.*
- ☑ *Neither the fraud commission nor the insurance commissioner has acted to ensure that the assessments employers pay are necessary or are put to the best use for reducing the overall cost that fraud adds to the workers' compensation system.*
- ☑ *Shortcomings also exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud.*

continued on next page

RESULTS IN BRIEF

The Fraud Assessment Commission (fraud commission) and the insurance commissioner have not adequately implemented a strategy to ensure that funds assessed against employers—averaging approximately $30 million for each of the past five years—are required and are used in the most effective manner to reduce the costs that fraud adds to the workers' compensation system.

The California Constitution authorizes the Legislature to create and enforce a workers' compensation system that requires employers to compensate workers for job-related injuries and illnesses. Employers must pay for these benefits to injured workers either by purchasing workers' compensation insurance from an insurer or directly through self-insurance. The total cost of California's workers' compensation system has more than doubled recently—growing from about $9.5 billion in 1995 to about $25 billion in 2002—giving rise to sharp increases in employers' workers' compensation insurance premiums and prompting several efforts to reform various aspects of the system. Some of these reform efforts have been targeted at combating the fraud alleged to exist in the workers' compensation system, including fraud perpetrated by workers, medical and legal providers, insurers, and employers.

One of the reform efforts, Senate Bill 1218 passed in 1991, created an annual assessment collected from employers and paid into a fund dedicated to increasing the investigation and prosecution of fraud in the workers' compensation system. This legislation also established the fraud commission, which is responsible for determining the annual assessment after considering the advice and recommendations of the Department of Insurance's Fraud Division (fraud division) and the insurance commissioner.

However, neither the fraud commission nor the insurance commissioner has acted to ensure that the assessments employers pay are necessary or are put to the best use for reducing the overall cost that fraud adds to the workers' compensation system. Specifically, no meaningful steps have been taken to measure the extent and nature of fraud in the system. Instead, the fraud commission, the insurance

- ☑ ***Because the fraud division has not conducted adequate strategic planning, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys.***

- ☑ ***The fraud division does not facilitate an effective system to obtain referrals of suspected fraud from insurers and other state entities involved in employment related activities.***

- ☑ ***The fraud division's special investigative audit unit lacks a program that effectively targets insurers to achieve maximum compliance with suspected fraud reporting requirements, a standardized approach to conducting audits, timely reports and follow-up, and effective penalties to promote compliance.***

- ☑ ***Improvement is needed in sharing information between the Department of Industrial Relations (Industrial Relations) and the fraud division to identify potential workers' compensation fraud.***

- ☑ ***Industrial Relations has not implemented three statutory programs intended to identify and prevent workers' compensation fraud.***

commissioner, and the fraud division rely primarily on anecdotal testimony from stakeholders in the workers' compensation community, unscientific estimates, and descriptions of local cases involving fraud included in county district attorneys' applications for antifraud program grants. The Coalition Against Insurance Fraud has pointed out that the most common rationale for measuring fraud is that finding an effective solution to the problem requires knowing its extent. According to the fraud division chief, lacking the necessary resources and expertise, the fraud division cannot measure the extent and nature of fraud in the workers' compensation system or determine the effectiveness of activities to deter it.

Additionally, neither the fraud commission nor the insurance commissioner has made a meaningful effort to establish baselines for measuring the current level of fraud and gauging future changes in that level. If baselines were available, it would be possible to systematically and periodically measure the level of fraud, using available data, to determine the effectiveness of programwide strategies in reducing fraud in the workers' compensation system. Instead, the fraud division collects and publishes discrete statistics showing the number of investigations, arrests, convictions, and restitutions; revealing only that some sources of fraud may have been removed, not whether antifraud efforts are cost-effective—that is, whether they have reduced the overall cost that fraud adds to the system by as much or more than what is spent annually to fight it.

Further, the fraud commission and the insurance commissioner have no overall strategy for using the funds assessed against employers to reduce fraud in the workers' compensation system most effectively and efficiently. Such a strategy could be translated into the goals and objectives, priorities, and measurable targets that state and local entities involved in fraud reduction efforts need to work effectively. These systemwide goals and priorities could be broken down into regional elements to accommodate any unique regional fraud problems. Having a measured level of fraud and a strategy for combating it could provide the fraud commission with criteria to use in arriving at the appropriate assessment to be paid by employers each year and in allocating the fraud assessment funds to state and local entities that are considered most effective in the efforts to reduce fraud.

- ☑ *The formulas Industrial Relations uses to calculate and collect the workers' compensation fraud assessment surcharges have, in recent years, consistently resulted in insured employers being overcharged.*
- ☑ *Although Industrial Relations suspects that some insurers do not report and remit all of the fraud assessments they collect from employers, it states it does not have the authority, nor has it established a process, to verify that insurers remit all of the fraud assessments they collect from employers.*

To assure California's employers that their fraud assessment has been effectively used to reduce the amount of fraud and thereby reduce the overall cost of the workers' compensation system, the fraud commission and the insurance commissioner need (1) a systematic effort to measure the extent of workers' compensation fraud in the system and the types of fraudulent activities most responsible for driving up premiums, (2) an overall strategy to combat them, and (3) a means to periodically evaluate the effectiveness of the efforts (at both the state and local level) to reduce the occurrence of those types of fraud. Neither the fraud commission nor the insurance commissioner has met these three requirements. Simply put, they cannot justify the amount employers are assessed each year to combat fraud. According to some members of the fraud commission, one of the motivations behind the chosen funding level is to levy an assessment that allows both the fraud division and county district attorneys to maintain their current effort in pursuing workers' compensation fraud. However, at the December 2003 meeting to determine the fiscal year 2004–05 aggregate fraud assessment, one member of the fraud commission voiced her concern that the commission was voting without enough information to make an informed decision.

Shortcomings also exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud. A review panel comprising fraud commission members, representatives of the fraud division and the Department of Industrial Relations (Industrial Relations), and an independent criminal expert makes recommendations to the insurance commissioner regarding how to allocate fraud assessment funds to district attorneys who have applied for grants. In making its recommendations, the review panel evaluates grant applications and uses the recommendations it receives from fraud division staff who also conduct a review of the grant applications. However, both the fraud division and the review panel fail to consistently apply criteria or document the rationale they use in making funding recommendations. Rather, each review panel member uses a personal, subjective set of criteria when developing recommendations for grant awards, without retaining any evidence of the basis of any decision. Further, the panel members do not share their decision-making criteria or rationale with the district attorneys or with other review panel members. Nor does the fraud division retain documentation showing the reasoning it used to arrive at its funding recommendations to the review panel. As a result, neither the review panel nor

the fraud division staff can provide evidence justifying their decisions to recommend specific grant awards, leaving the process open to the perception that it may not be equitable.

Controls intended to restrict how county district attorneys use their grants of fraud assessment funds to pay for indirect costs are not always effective. Department of Insurance regulations allow county district attorneys three options for charging counties' indirect costs to fraud assessment grants; each option is intended to place a limit on these charges. However, one option is based on cost rate proposals approved under requirements of the United States Office of Management and Budget, without any input from the fraud commission or insurance commissioner, and does not provide the control of charges of indirect costs provided by the other two options. As a result, one county district attorney charges county administrative costs to the grant at a rate equal to 43 percent of the total salaries and wages charged to the grant.

Because the fraud division has not conducted adequate strategic planning it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys. The fraud division pays for its workers' compensation antifraud activities using its share of the fraud assessment funds—averaging more than $13 million per year over the five years ending with fiscal year 2002–03—that are levied on California employers.

Comprehensive strategic planning would require that the fraud division (1) take specific steps to identify all its responsibilities for the workers' compensation antifraud program, (2) establish and prioritize goals and define the necessary objectives to accomplish them, (3) establish timelines and action plans for completing each objective and allocate the available resources based on its priorities, and (4) define benchmarks for each activity that can be used to evaluate performance outcomes and reset targets. The fraud division has largely left all these tasks undone.

Lacking a sound strategic plan, the fraud division dedicates too few of its workers' compensation fraud resources to the noninvestigative activities that its statutory responsibilities demand. For example, the fraud division has put little effort into conducting the research necessary to measure the magnitude of the various types of workers' compensation fraud, a yardstick that could help the fraud division guide its antifraud approach

and measure its actions and effectiveness in reducing the fraud problem. Further, the fraud division has not developed the information on fraud needed to prepare reports for individuals and entities overseeing the antifraud program, such as the insurance commissioner, the Legislature, and the fraud commission. However, the fraud division's ability to successfully identify goals and objectives is somewhat limited because, as previously discussed, the fraud commission and the insurance commissioner have not established a statewide strategy for the antifraud program.

In addition, our review of workers' compensation fraud cases in its case management database reveals that the fraud division could manage its investigative efforts more effectively. For example, 87 percent of the referrals of suspected workers' compensation fraud the division receives do not end up in the hands of district attorneys for prosecution. Between September 2001 and December 2003, the fraud division spent more than 16 percent of its investigative hours on cases that it closed and did not submit for prosecution. Moreover, based on past trends, one-third of the hours charged to open cases as of December 2003 will probably be spent on cases not submitted to district attorneys for prosecution. Similarly, during the same time period, the division closed 83 percent of the high-impact, high-priority cases referred to it without submitting the cases to district attorneys, frequently citing insufficient evidence as the reason.

Because the reporting requirements established by the Department of Insurance are ambiguous, independent audit reports submitted by county district attorneys participating in the antifraud program do not assure the fraud division that the district attorneys use grants of fraud assessment funds appropriately. Although an audit unit within the Department of Insurance conducts reviews of district attorneys' use of workers' compensation fraud assessment funds that are effective and have resulted in the detection and recovery of questionable expenditures, the audit unit's limited resources hinder its ability to audit all district attorneys, including those receiving the largest grants. As a result, the fraud division cannot verify that county district attorneys receiving grants use the funds in accordance with state law, Department of Insurance regulations, and the terms of the grant agreements.

The fraud division does not offer insurers an effective system for referring suspected workers' compensation fraud to the fraud division. An effective fraud referral system is important to the

fraud division because its ability to investigate is dependent on the number and quality of referrals it receives. Despite a legal requirement to investigate suspected fraud and to report cases that show reasonable evidence of fraud, insurers' frequency of reporting varies significantly. In fact, some of the larger insurers in the workers' compensation system reported no suspected fraud referrals in 2001 and 2002. The chief of the fraud division stated that past regulations poorly defined when insurers should refer suspected fraud to the fraud division. The Department of Insurance and the fraud division have recently adopted emergency regulations in an attempt to better define when reporting is required. Additionally, the fraud division is currently working to increase and improve its monitoring of insurers' special investigative units, which are responsible for reporting fraud. Included in the fraud division's planned improvements is developing a new method for auditing the special investigative units.

Nonetheless, the fraud division's efforts to ensure that it receives referrals of suspected fraud from insurers still have many internal weaknesses. A lack of strategic planning has left the fraud division's special investigative audit unit without a program that effectively targets insurers to achieve maximum compliance with reporting requirements, a standardized approach to its audits that will ensure an adequate review, timely reports and follow-up on audit findings, and effective penalties to promote compliance.

Improving its ability to gather information from other departments could also help the fraud division identify potential workers' compensation fraud. Specifically, the Division of Labor Standards Enforcement (DLSE) within Industrial Relations investigates violations of certain labor laws, including the failure to provide workers' compensation insurance and benefits to employees. However, the DLSE does not routinely refer its findings to the fraud division for consideration of possible criminal prosecution. During 2003, the DLSE cited nearly 1,300 employers for failing to provide workers' compensation insurance and benefits for their employees. Having information on some of these cases, particularly those involving repeat offenders, might have alerted the fraud division of noncompliance with the law and helped it detect potentially fraudulent activities. The fraud division chief told us he has sought to improve information sharing between the fraud division and divisions within Industrial Relations.

Further, Industrial Relations has not implemented three mandated programs that would enhance efforts to identify and prevent workers' compensation fraud. Recent legislation required the DLSE, in conjunction with the Employment Development Department and the Workers' Compensation Insurance Rating Bureau, to establish a program to identify employers that fail to secure workers' compensation insurance for their employees. This requirement is similar to a pilot project that demonstrated that such a program provides an effective and efficient method for discovering illegally uninsured employers. Industrial Relations' Division of Workers' Compensation (DWC) is also required by recent legislation to implement a protocol for reporting suspected medical provider fraud and a program to annually warn employers, claims adjusters and administrators, medical providers, and attorneys who participate in the workers' compensation system against committing workers' compensation fraud. Notification of the legal risks is regarded as an important step in deterring fraud.

Finally, improvement is needed in the process used to collect the fraud assessment funds that finance increased antifraud activities. Specifically, the formulas Industrial Relations uses to calculate the workers' compensation fraud assessment surcharge rates have, in recent years, consistently resulted in insured employers being overcharged. In addition, Industrial Relations suspects that not all insurers correctly report and remit all the workers' compensation fraud assessment surcharges they collect from employers. Industrial Relations estimates that a range of roughly $8 million to more than $13 million has been unreported and unremitted during 1999 through 2001. However, Industrial Relations stated it does not have the authority, nor has it established a process, to verify that insurers remit all of the fraud assessment surcharges collected from employers.

RECOMMENDATIONS

To better determine the assessment to levy against employers each year for use in reducing fraud in the workers' compensation system, the fraud commission and the insurance commissioner should direct the fraud division to measure the nature and extent of fraud in the workers' compensation system. To establish benchmarks to gauge the effectiveness of future antifraud activities, these measures should include analyses of available data from insurers and state departments engaged in employment-related activities, such as Industrial Relations

and the Employment Development Department. In addition, the insurance commissioner should consider reactivating an advisory committee comprising stakeholders focused on reducing fraud in the workers' compensation system to contribute to the data analyses, provide input about the effects of fraud, and suggest priorities for reducing it. This advisory committee should meet regularly and in an open forum to increase public awareness and the accountability of the process.

Given the nature and extent of fraud in the system, the fraud commission and the insurance commissioner and his staff should design and implement a strategy to reduce workers' compensation fraud. The strategy should be systemwide in scope and include objectives, priorities, and measurable targets that can be effectively communicated to the fraud division and the county district attorneys participating in the antifraud program. Efforts to achieve the strategy targets should be both a condition for receiving awards of fraud assessment funds and a measure of how well the fraud division and the county district attorneys pursue the systemwide objectives. The strategy should clearly define the roles and responsibilities of the participants in antifraud activities.

To gather the information it needs to determine the annual amount to assess employers to fight fraud in the workers' compensation system, the fraud commission should take the following steps:

- Revamp its decision-making process so that it includes the best information available, including (1) the results of the Department of Insurance's analyses of the nature and extent of fraud in the workers' compensation system, once they are completed; (2) analysis of the effectiveness of efforts by the fraud division and district attorneys in the prior year to reduce fraud in accordance with their respective antifraud program objectives; and (3) any newly emerging trends in fraud schemes that should receive more attention.

- Request an annual report from the fraud division that outlines (1) its objectives from the prior year that are linked to measurable outcomes (2) and its objectives for the ensuing year, together with estimates of the expenditures the fraud division needs to make to accomplish those objectives.

- Request, in addition to the information currently required of each county district attorney planning to participate in the antifraud program, a report listing the district attorney's

accomplishments in achieving the goals and objectives outlined in the prior year's application and the goals and objectives for the ensuing year. The report should also include the estimated cost of the grant year's activities to achieve the district attorney's goals and objectives and a description of how those goals and objectives align with the program goals described by the fraud commission and the insurance commissioner.

To better ensure that fraud assessment funds are distributed to district attorneys so as to most effectively investigate and prosecute workers' compensation fraud and increase their accountability in using the funds, the fraud commission and the insurance commissioner should take the following steps:

- Develop and implement a process for awarding fraud assessment grants that provides for consistency among those making funding recommendations by incorporating standard decision-making criteria and a rating system that supports funding recommendations.

- Include in the decision-making criteria how well county district attorneys' proposals for using fraud assessment funds align with the strategy and priorities developed by the fraud commission and the insurance commissioner, as well as the district attorneys' effectiveness in meeting the prior year's objectives.

- Document the rationale for making decisions on recommendations for grant awards.

- Change the past policy of awarding the base portion of fraud assessment grants to county district attorneys exclusively on whether they submit a completed application by required deadlines and instead, make recommendations for total grant awards, including the base allocations, on evaluations of county district attorneys' plans that include how they will use the funds, as required by Department of Insurance regulations.

- Continue current efforts to establish performance measures to use in evaluating the effectiveness of the fraud division and participating district attorneys in reducing workers' compensation fraud. The measures can also assist in determining recommendations for grant awards to the county district attorneys and the fraud division.

To ensure that it fulfills all aspects of its role in the workers' compensation antifraud program, the fraud division should take the following steps:

- Recognize its responsibilities beyond investigating fraud: (1) conducting the research needed to advise the fraud commission and the insurance commissioner on the optimum aggregate assessment needed by the program annually to fight workers' compensation fraud, (2) using documented past performance and future projections to advise on the most effective distribution of the funds assessed to investigate and prosecute workers' compensation fraud, and (3) reporting on the economic value of insurance fraud and making recommendations to reduce it.

- Modify its business plan to meet noninvestigative responsibilities, including establishing appropriate goals and objectives, activities, and priorities.

- Establish benchmarks to measure its and the district attorneys' performance in meeting goals and objectives and to determine whether the antifraud program is operating as intended and resources are appropriately allocated.

- Reevaluate the process it has established for insurers and other state entities involved in employment-related activities to report suspected fraud. The fraud division should identify the type of referrals and level of evidence it requires to reduce the number of hours it spends on referrals that it ultimately does not pass on to county district attorneys for prosecution.

To justify the use of fraud assessment funds, the fraud commission and the insurance commissioner should require the fraud division to conduct a return-on-investment analysis for the workers' compensation antifraud program as a whole and to annually report the results to the fraud commission and the insurance commissioner.

To improve the level of assurance contained in the independent audit reports submitted by county district attorneys regarding fraud assessment funds being spent for program purposes, the fraud division should do the following:

- Clarify its expectations for the independent audits by seeking a change in the Department of Insurance regulations that require audit reports to provide an opinion on county

district attorneys' level of compliance with key provisions of the applicable laws, regulations, and terms of the fraud assessment grants.

- Ensure that county district attorneys comply with the independent audit requirements and submit their audit reports in a timely manner.

To ensure that it receives the suspected fraud referrals it needs from insurers to efficiently investigate suspected fraud, the fraud division should continue its efforts to remove the barriers that prevent insurers from providing the desired level of referrals. Additionally, the Department of Insurance should seek the necessary legal and regulatory changes in the fraud-reporting process. Barriers to adequate referrals include the following:

- Lack of a uniform methodology and standards for assessing and reporting suspected fraud.

- Regulations that poorly define when insurers should report suspected fraud to the fraud division.

- Perceived exposure to civil actions when criminal prosecutions of referrals are not successful.

Given the number of referrals of suspected fraud cases by insurers that the fraud division has decided not to investigate because of a perceived lack of sufficient evidence, the fraud division should work with insurers to reduce the number of referrals that are not likely to result in a successful investigation or prosecution, thereby preserving limited resources. It should also work to ensure that the referrals that insurers do make contain the level of evidence necessary for the fraud division to assess the probability of a successful investigation and prosecution.

Once the fraud division has determined the level of evidence included with the suspected fraud referrals it needs from insurers, it should implement a strategy for its special investigative audit unit to focus the unit's limited resources on determining whether insurers are following the law in providing the referrals the fraud division needs.

To help the fraud division investigate employers that fail to secure payment for workers' compensation insurance for their employees, the DLSE should track employers that do not provide

workers' compensation insurance for their employees and report to the fraud division any employer that repeatedly fails to provide workers' compensation insurance.

To ensure that it effectively targets employers in industries with the highest incidence of unlawfully uninsured employers, the DLSE should establish a process that uses data from the Uninsured Employers Fund, the Employment Development Department, and the Workers' Compensation Insurance Rating Bureau, as required by law.

To provide a mechanism to allow reporting of suspected medical provider fraud, the DWC should implement the fraud-reporting protocols required by law.

To help deter workers' compensation fraud, the DWC should warn participants in the workers' compensation system of the penalties of fraud, as required by law.

To avoid overcharging the State's insured employers for the workers' compensation fraud assessment, Industrial Relations should work with the Workers' Compensation Insurance Rating Bureau to improve the accuracy of the projected premiums for the current year, which it uses to calculate the fraud assessment surcharge to be collected from insured employers.

To make certain that insurers do not withhold any portion of the fraud assessment surcharge, Industrial Relations should seek the authority and establish a method to verify that insurers report and submit the fraud assessment surcharges they collect from employers.

AGENCY COMMENTS

The insurance commissioner, Fraud Assessment Commission, and the Labor and Workforce Development Agency generally agree with our recommendations and each provides comments on our findings. Our comments follow their respective responses. ■

INTRODUCTION

BACKGROUND

The California Constitution authorizes the Legislature to create and enforce a workers' compensation system that requires employers to provide benefits to workers who suffer work-related injuries and illnesses. Injured workers are entitled to receive all medical care that is reasonably required to cure and relieve the effects of the disability. Additionally, any injured worker who cannot return to work within three days is entitled to receive disability payments to partially replace lost wages. A worker permanently disabled or unable to return to the same line of work due to the nature of the injury is entitled to receive a vocational rehabilitation voucher and, in some cases, a permanent disability benefit. In exchange for these no-fault insurance benefits, the law designates the limited workers' compensation benefits as the exclusive remedy for injured employees against their employers, even if the injury is due to employer negligence. To secure these benefits for injured workers, employers either make premium payments to purchase workers' compensation insurance or pay for benefits directly through self-insurance.

Unlike most social insurance programs, such as Social Security or unemployment compensation, a single government or private agency does not administer workers' compensation in California. Rather, employers, insurers, claims administrators, medical service providers, and others have roles in processing workers' claims for benefits within the workers' compensation system.

The total cost of California's workers' compensation system has more than doubled recently, growing from about $9.5 billion in 1995 to about $25 billion in 2002. This dramatic rise in costs has caused sharp increases in the workers' compensation insurance premiums employers pay, prompting efforts to reform various aspects of the system. Several of these reform efforts aim to combat the amount of workers' compensation fraud. Fraud in a variety of forms is alleged to occur in the workers' compensation system, perpetrated by workers, medical and legal providers, or employers and insurers.

LEGISLATION DESIGNED TO ENHANCE THE DETECTION OF FRAUD

Three statutes enacted since 1991 were either wholly or partially intended to enhance the State's efforts to combat workers' compensation fraud. Chapter 116, Statutes of 1991 (Senate Bill 1218), contained provisions that increased the penalties for workers' compensation fraud and provided a means to assess employers—through their workers' compensation premiums or directly if self-insured—an annual amount to be used to investigate and prosecute fraud in the workers' compensation system. This legislation also established the Fraud Assessment Commission (fraud commission), which is responsible for determining the annual assessment (a minimum of $3 million a year) after considering the advice and recommendations of the Department of Insurance's Fraud Division (fraud division) and the insurance commissioner. The legislation provided that the fraud commission be composed of seven members: two representing organized labor, two representing self-insured employers, one representing insured employers, one representing workers' compensation insurers, and the president of the State Compensation Insurance Fund (State Fund) or a designee. The governor appoints all the members of the fraud commission except the seat held by the president of the State Fund. Finally, the legislation required that insurers or agents authorized to act on the insurers' behalf release evidence related to suspected workers' compensation fraud to specified government agencies and to report suspected fraudulent claims.

Chapter 6, Statutes of 2002 (Assembly Bill 749), expanded the types of antifraud activities that can be funded by the annual fraud assessments to include investigating and prosecuting employers that willfully fail to secure workers' compensation benefits for their employees. This provision is generally targeted at employers that do not purchase workers' compensation insurance and self-insured employers that fail to pay benefits to which their employees are entitled. This legislation also required the Department of Industrial Relations' (Industrial Relations) labor commissioner to establish a program, in cooperation with the Employment Development Department, licensed rating bureaus, and other entities, to identify employers that are unlawfully uninsured. This requirement is similar to a pilot project coordinated by the Commission on Health and Safety and Workers' Compensation during the mid- to late-1990s in which Industrial Relations was successful in identifying uninsured employers by checking the Employment

Development Department's employment records against the insurance policy information from the databases of the Workers' Compensation Insurance Rating Bureau.

Chapter 639, Statutes of 2003 (Senate Bill 228), required the administrative director of the Division of Workers' Compensation (DWC) within Industrial Relations to coordinate with the fraud division, the State's Medicaid Assistance Program (Medi-Cal) Fraud Task Force, and the Department of Justice's Medi-Cal fraud bureau to adopt protocols similar to those adopted by the fraud division for insurers, employers, claims administrators, and others for reporting medical provider fraud within the workers' compensation system. The legislation directed that the protocols accommodate the required reporting by any insurer, self-insured employer, third-party administrator (claims administrator), workers' compensation administrative law judge, audit unit, attorney, or other person who believes that a person or entity providing medical care within the workers' compensation system has submitted a fraudulent claim.

ENTITIES INVOLVED IN REDUCING FRAUD AND ENFORCING COMPLIANCE WITH LAWS GOVERNING THE WORKERS' COMPENSATION SYSTEM

Several state and local agencies are involved in some type of activity to reduce the amount of fraud in the workers' compensation system and ensure that relevant laws are followed.

The Fraud Assessment Commission

To fund the current level of investigation and prosecution of workers' compensation fraud, the Legislature created the fraud commission, which annually determines the aggregate amount to assess employers to fund both the fraud division's activities in investigating suspected fraud and local district attorneys' efforts to investigate and prosecute cases involving workers' compensation fraud. At its annual meeting, the fraud commission solicits input from the fraud division and district attorneys to ascertain the extent to which workers' compensation fraud is a problem in their respective jurisdictions and to identify a statewide funding level adequate to fight fraud. This aggregate assessment is collected in the form of a surcharge levied by Industrial Relations from employers on behalf of the fraud commission and deposited in a special workers' compensation fraud account in the Insurance Fund. However,

when Industrial Relations collects more than the annual amount authorized by the fraud commission, it places the excess amount in its special deposit fund and uses that amount to offset the following year's assessment.

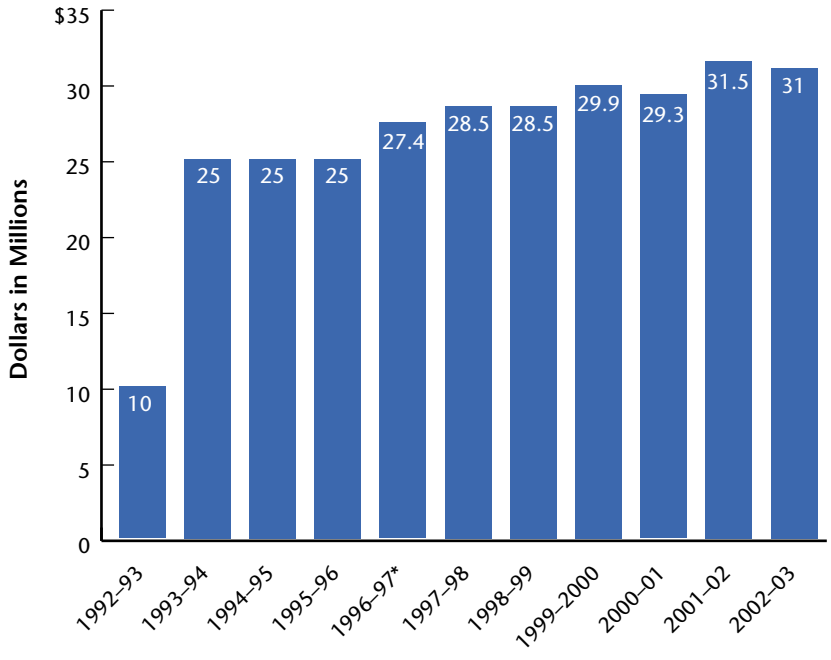
From the annual aggregate assessment, deductions are made for incidental program expenses that, according to Department of Insurance regulations, include the costs incurred by the Department of Insurance and Industrial Relations to administer the program and may also include fraud commission expenses, administrative support for the fraud division's antifraud program, and other costs. The law then requires that, of the remaining aggregate amount assessed annually by the fraud commission, at least 40 percent be provided to the fraud division for enhanced investigative efforts and at least 40 percent be distributed to local district attorneys to investigate and prosecute workers' compensation fraud. The remaining 20 percent of the aggregate assessment must be split between the fraud division and the local district attorneys at the discretion of the fraud commission. Correspondence we obtained from the fraud division indicates that for the past two fiscal years, the split has been 45 percent to the fraud division and 55 percent to the local district attorneys. According to the law, the fraud assessment funds can be used only for enhanced investigation and prosecution of workers' compensation fraud and the willful failure to provide workers' compensation insurance or to pay for the benefits to which workers are legally entitled. Figure 1 shows the historical level of this fraud assessment.

The Department of Insurance's Fraud Division

The fraud division within the Department of Insurance conducts investigations of suspected insurance fraud and carries out other antifraud efforts. Established in 1979, the fraud division has grown to 208 authorized peace officer positions, 182 of which were filled as of January 2004, and 78 non-peace officer positions, 66 of which were filled as of January 2004. These positions provide the investigative and support services for the fraud division's automobile, workers' compensation, and property and casualty antifraud programs. Under its workers' compensation antifraud program, the fraud division's role since 1991 has been primarily to receive referrals from insurers and others in a position to detect potential workers' compensation fraud; investigate referrals that show merit; and, once it has gathered sufficient evidence, refer cases to county district attorneys for prosecution. The fraud division also performs

FIGURE 1

Aggregate Antifraud Assessment
Fiscal Years 1992–93 Through 2002–03



Source: Fraud Division's Annual Program Reports.

Note: The aggregate assessment for fiscal year 1992–93 includes a partial year's assessment for fiscal year 1991–92, the year the antifraud program was enacted.

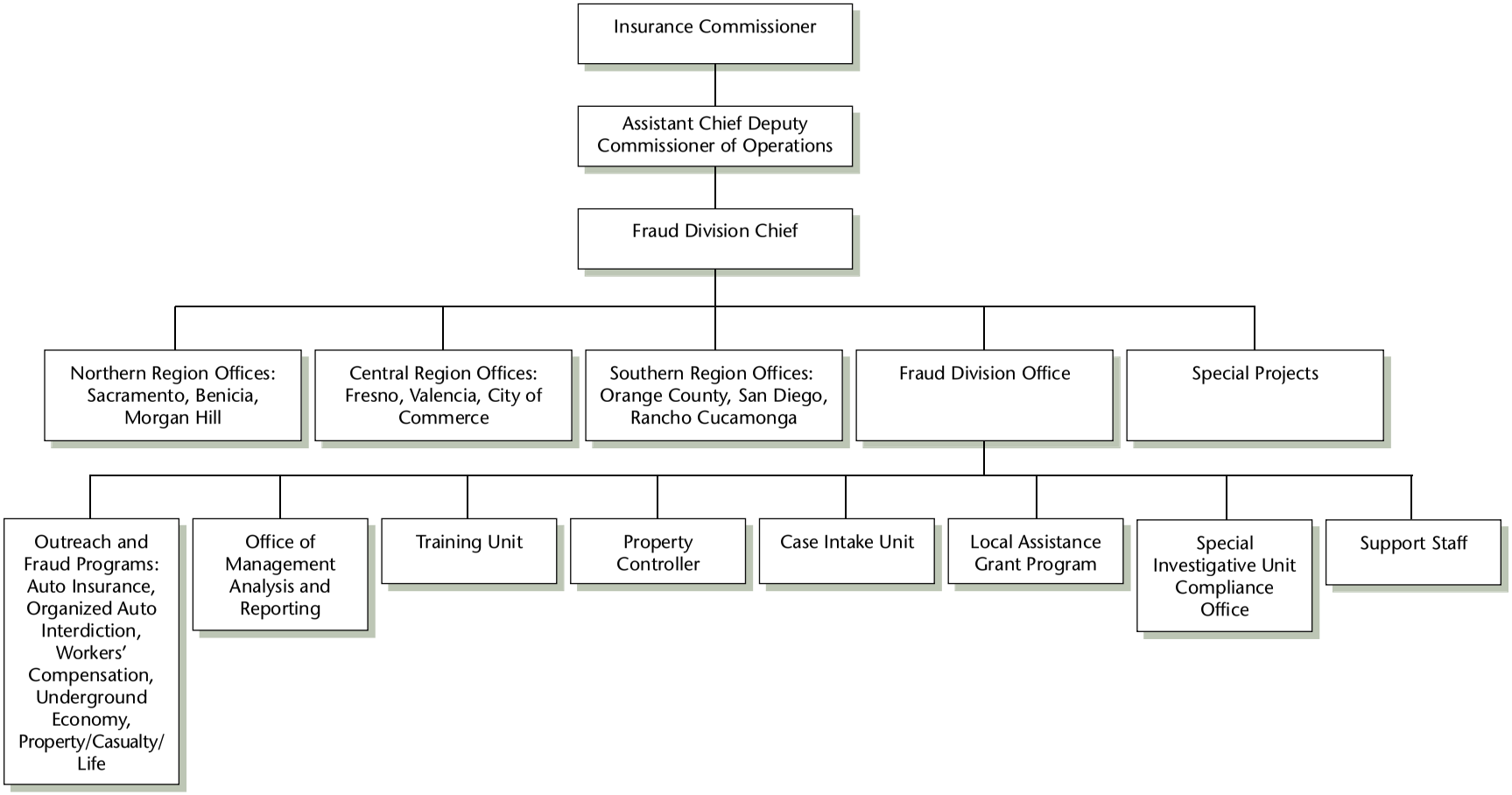
* Amount includes $2.4 million in restitution funds directed to district attorneys.

outreach to the workers' compensation community by providing information and training on how to detect and deter fraud. Figure 2 on the following page shows the current organization of the fraud division.

County district attorneys receive fraud assessment funds to investigate and prosecute workers' compensation fraud. Through the nine regional offices it maintains throughout the State, the fraud division works jointly with county district attorneys to prosecute and deter workers' compensation fraud. Participation by county district attorneys in the workers' compensation antifraud program is voluntary through a grant application process. Figure 3 on page 19 shows the number of county district attorneys who have participated in the workers' compensation antifraud program since the inception of the grant application process in fiscal year 1991–92. As of fiscal year 2002–03, 34 county district attorneys were participating in the program.

FIGURE 2

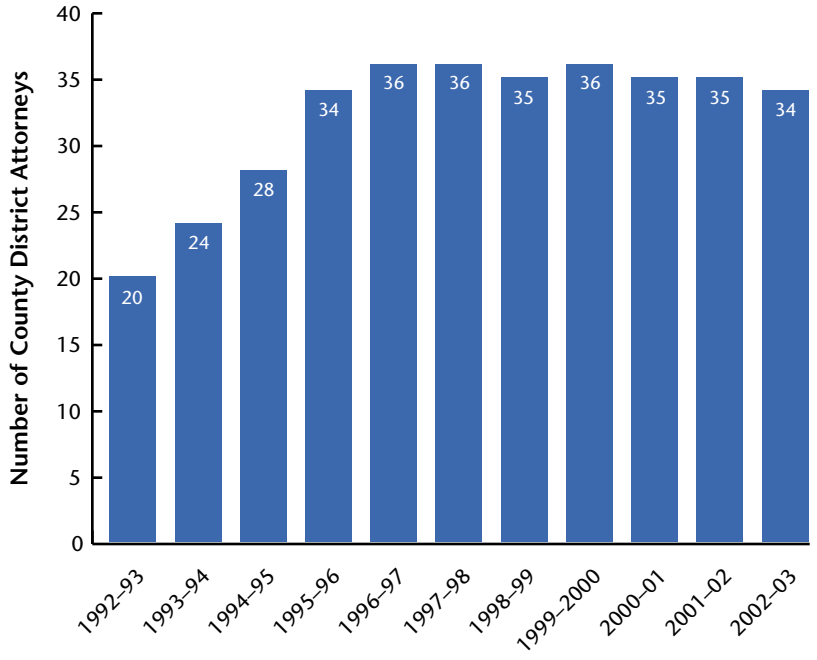
Fraud Division Organization Chart


Insurance Commissioner
Assistant Chief Deputy Commissioner of Operations
Fraud Division Chief
Northern Region Offices: Sacramento, Benicia, Morgan Hill
Central Region Offices: Fresno, Valencia, City of Commerce
Southern Region Offices: Orange County, San Diego, Rancho Cucamonga
Fraud Division Office
Special Projects
Outreach and Fraud Programs: Auto Insurance, Organized Auto Interdiction, Workers' Compensation, Underground Economy, Property/Casualty/ Life
Office of Management Analysis and Reporting
Training Unit
Property Controller
Case Intake Unit
Local Assistance Grant Program
Special Investigative Unit Compliance Office
Support Staff

Source: Fraud Division, Department of Insurance.

FIGURE 3

Number of County District Attorneys Participating in the Antifraud Program



Source: Fraud Division, Department of Insurance.

The law contains specific requirements that participants in the workers' compensation system report suspected fraud to local law enforcement agencies and the fraud division. For example, the Insurance Code states that any insurer or licensed rating organization that reasonably believes it has knowledge of a fraudulent act involving a workers' compensation claim or policy shall notify the local district attorney's office and the fraud division. Moreover, the law requires each insurer to maintain a special investigative unit to detect, investigate, and refer suspected workers' compensation fraud to the appropriate authority.

The Review Panel

Department of Insurance regulations establish a review panel whose function is to review district attorneys' grant applications for fraud assessment funds and provide funding recommendations to the insurance commissioner. The review panel comprises two members of the fraud commission, the chief of the fraud division

or a designee, the director of Industrial Relations or a designee, and an expert in consumer crime investigation and prosecution designated by the insurance commissioner.

After the annual aggregate assessment has been determined, the insurance commissioner sends a request for application to each county district attorney in the State. Each district attorney applying for funds must submit a grant application to the fraud division and the review panel describing his or her plans for investigating and prosecuting workers' compensation fraud in that county. The review panel then evaluates each application, using application requirements specified in Department of Insurance regulations.

Before distributing funds to district attorneys, the insurance commissioner must determine the most effective distribution of the fraud assessment funds, based on the recommendation of the review panel and with the advice and consent of the fraud division. Under the law, the ultimate goal of the funding decisions is to achieve the most effective distribution of the fraud assessment funds to further the investigation and prosecution of workers' compensation fraud cases and cases relating to employers' willful failure to secure workers' compensation benefits for their employees. The insurance commissioner's determination of the annual funding distribution is then sent to the fraud commission for its written advice and consent.

Other Activities Designed to Fight Workers' Compensation Fraud

In addition to the requirements that insurers, other entities, and individuals report suspected fraud, departments within state government conduct other activities to detect fraud or noncompliance with workers' compensation law:

- The fraud division maintains a unit to audit insurers' compliance with the requirement to investigate and report suspected fraud.

- An audit unit in the DWC conducts reviews to measure insurers' compliance in providing benefits, including workers' compensation benefits, to injured workers.

- Industrial Relations' Division of Labor Standards Enforcement (DLSE) conducts reviews to measure employers' compliance with various labor laws, including the requirement to secure workers' compensation benefits for their employees.

- The Ethics and Operational Compliance Unit, an audit unit within the Department of Insurance, reviews some county district attorneys' use of their grants of workers' compensation fraud assessment funds.

SCOPE AND METHODOLOGY

Section 1872.83 of the Insurance Code (Chapter 6, Statutes of 2002), requires the Bureau of State Audits (bureau) to evaluate the effectiveness of the efforts of the fraud commission, the fraud division, the Department of Insurance, and Industrial Relations, as well as local law enforcement agencies, including district attorneys, in identifying, investigating, and prosecuting workers' compensation fraud and employers' willful failure to secure workers' compensation benefits for their employees.

To understand the roles and responsibilities of the State's workers' compensation antifraud efforts, we reviewed the relevant sections of the California Labor Code and Insurance Code, as well as the California Code of Regulations. To comprehend the activities conducted by the state departments, the fraud commission, and other entities involved in antifraud efforts, we interviewed key management staff of the Department of Insurance, Industrial Relations, members of the fraud commission, members of the review panel, and a representative of the California District Attorneys Association. On April 19, 2004, the governor signed into law a bill—Senate Bill 899—relating to workers' compensation reform. We did not evaluate what, if any, effect this legislation might have on the issues discussed in this report.

To identify and understand any existing strategy to carry out the workers' compensation antifraud program backed by fraud assessment funds and to identify any goals and priorities for implementing such a strategy, we interviewed key management staff of the Department of Insurance and the fraud division, as well as members of the fraud commission, and reviewed various documents and records. We also interviewed members of the fraud commission and reviewed records of its meetings to comprehend the process used to determine annual funding levels for antifraud activities authorized by law and to identify any efforts to establish that the funds are used in a manner that will result in the most effective investigation and prosecution of workers' compensation fraud.

To comprehend and evaluate the process for determining the distribution of fraud assessment funds to county district attorneys who apply to participate in the workers' compensation antifraud program, we interviewed members of the review panel and the fraud division and reviewed the county district attorneys' applications for grant funds and any available documents used to evaluate those applications. Specifically, we reviewed the available documentation and interviewed fraud division staff and members of the review panel to identify any effort to establish that the fraud assessment funds are allocated to local district attorneys so as to most effectively investigate and prosecute workers' compensation fraud.

We asked key management staff from the fraud division about their strategic planning to meet the fraud division's responsibilities as contained in the Insurance Code. We reviewed the documents the fraud division made available to us to identify management's strategy, goals, and priorities in achieving the purpose of the workers' compensation antifraud program. We also asked fraud division managers about any efforts to measure the extent and nature of fraud in the workers' compensation system.

To determine how effective the fraud division is in investigating workers' compensation fraud referrals that result in submittal to district attorneys for prosecution and how efficiently it allocates its investigative resources, we reviewed the referrals contained in the fraud division's database concerning alleged workers' compensation fraud and the hours charged in investigating those referrals for the period September 2001 through December 2003. As part of this effort, we verified the reliability of the fraud division's database and found it sufficiently reliable for the purposes of this audit.

We interviewed fraud division managers and reviewed documents to assess the fraud division's effectiveness in reviewing and promoting insurers' compliance with the law's requirement to report suspected fraud to the fraud division. We also queried the fraud division's database of referrals of suspected workers' compensation fraud to understand insurers' compliance with the requirement to report suspected fraud, and we interviewed the manager of the special investigative unit at the State Fund to gain her perspective on the issues surrounding compliance with the requirement.

To identify the extent to which other state departments cooperate with the fraud division in sharing information about the actual or potential occurrence of fraud in the workers' compensation system, we interviewed key management staff from the DWC and the DLSE and reviewed documents to determine their level of activity to enforce labor laws, the likelihood that their activities will uncover actual or potential fraud, and the extent to which these two divisions report actual or suspected workers' compensation fraud to the fraud division or a district attorney.

We reviewed Industrial Relations' process for collecting the assessment authorized by the fraud commission to determine whether it followed the requirements of the law and its regulations, and we examined whether the funds are transferred to the Department of Insurance for use in antifraud efforts as authorized by the law.

To determine the effectiveness of the fraud division's efforts to establish accountability for the district attorneys' use of workers' compensation fraud assessment funds, we asked the fraud division about its efforts to monitor the district attorneys' spending of the fraud assessment funds. We also interviewed the chief of the Ethics and Operational Compliance Office within the Department of Insurance and reviewed his work papers and audits of county district attorneys' use of workers' compensation fraud assessment funds, and we reviewed audit reports of district attorneys' expenditures conducted by independent auditors.

Finally, to understand the fraud division's accountability over its use of fraud assessment funds, we reviewed its procedures to ensure that those funds are used exclusively for workers' compensation antifraud efforts. ■

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CHAPTER 1

Workers' Compensation Antifraud Efforts Lack Adequate Planning and Coordination, and Funding Is Not Determined Using Established Priorities

CHAPTER SUMMARY

The Fraud Assessment Commission (fraud commission) and the insurance commissioner have not developed a statewide vision and plan for fighting fraud in the workers' compensation system; therefore, neither can be certain that the antifraud assessment levied against California employers is being used to most effectively investigate, prosecute, and reduce fraud in the workers' compensation system. Antifraud efforts also lack an underlying strategy for estimating the amount of fraud in the system and for developing a statewide plan that prioritizes the actions needed to combat it, including a way to measure the plan's success in reducing fraud in the workers' compensation system. As a result, the fraud commission does not have adequate information on which to base its annual assessment, nor does it have the means to allocate the assessment in a manner that ensures that fraud is, in fact, reduced.

Because the fraud commission and the insurance commissioner have not identified the magnitude and nature of fraud in the workers' compensation system, they have not formulated or communicated objectives and measurable targets for reducing fraud to the entities responsible for investigating and prosecuting it. Consequently, they cannot be certain that the assessment levied on California's employers is at the appropriate level to control fraud, and they have no way to demonstrate that their efforts are having the desired effect of reducing the costs that fraud adds to the workers' compensation system. Additionally, uncertainty about the types of fraud being perpetrated and their magnitude severely hinders the ability of both the fraud commission and the insurance commissioner to identify priorities and assign to district attorneys and the Department of Insurance's Fraud Division (fraud division) the proper roles and responsibilities in identifying and fighting fraud.

Moreover, with no way to measure the success of their efforts, the fraud commission and the insurance commissioner cannot be certain that they are distributing fraud assessment funds to state and local entities to most effectively investigate and prosecute workers' compensation fraud. For example, rather than being based on performance measures, decisions regarding the distribution of fraud assessment funds are based on historical funding levels and a subjective review of funding requests.

THE FRAUD COMMISSION AND THE INSURANCE COMMISSIONER CANNOT BE CERTAIN THAT FRAUD ASSESSMENT FUNDS ARE EFFECTIVELY USED TO REDUCE FRAUD

Although the aggregate assessment has grown from $10 million in fiscal year 1992–93 to $34 million by fiscal year 2004–05, neither the fraud commission nor the insurance commissioner has taken adequate steps to ensure that the assessed amount is necessary or put to the best use for reducing the costs that fraud adds to the workers' compensation system.

The assessments levied on employers to fund the antifraud program have increased dramatically since the program's inception. In fiscal year 1992–93, the aggregate assessment was $10 million; by fiscal year 2004–05, it had grown to more than $34 million. However, neither the fraud commission nor the insurance commissioner has taken adequate steps to ensure that the antifraud assessment is necessary or is used to maximize the reductions in the costs that fraud adds to the workers' compensation system.

For example, no meaningful effort has been made to measure the extent and nature of fraud in the workers' compensation system or to develop a baseline against which to measure the effectiveness of future antifraud efforts. In addition, the program lacks an overall strategy for using the funds to reduce fraud most effectively and efficiently—a strategy that could be translated into objectives, priorities, and measurable targets to guide state and local entities involved in fraud reduction efforts. The measured level of fraud and the strategy for combating it could be used as criteria for determining the appropriate assessment to levy against employers each year and for allocating those funds to state and local entities that participate in the antifraud effort. Instead, the fraud assessment funds are used each year to finance the independent efforts of the district attorneys, with each attorney pursuing individual objectives and priorities for a particular county's antifraud program. Without a systematic effort to measure the extent of fraud in the workers' compensation system, determine the types of fraud most responsible for driving up insurance premium rates, create an overall strategy to combat fraud, and establish a process to periodically evaluate the effectiveness of antifraud efforts (at both the state and local level), neither the fraud commission nor

the insurance commissioner can assure California's employers that their fraud assessments are being well spent. Simply put, the fraud commissioner and the insurance commissioner cannot justify the annual antifraud assessment.

An August 2001 report by the Commission on Health and Safety and Workers' Compensation identifies six major questions regarding workers' compensation fraud that need to be answered to develop an effective and efficient strategy (see the text box). Although the fraud commission, with the advice and recommendations of the insurance commissioner, assessed employers $34 million for fiscal year 2004–05 to pay for antifraud activities, some of these questions remain substantially unanswered or unresolved.

Questions for Developing a Strategy to Combat Fraud in the Workers' Compensation System

- Is workers' compensation fraud a major problem?
- What should be the scope of the antifraud campaign?
- What should be the focus and priority of antifraud efforts?
- What should be the source and level of funding for antifraud efforts?
- Should there be a greater interagency coordination of antifraud efforts?
- Are there any new ideas or innovative approaches that might improve the antifraud program?

Source: Commission on Health and Safety and Workers' Compensation.

The Extent and Nature of Fraud Within the Workers' Compensation System Is Not Adequately Measured or Monitored

Neither the fraud commission nor the insurance commissioner has made a meaningful attempt to measure how much and what types of fraud exist in the workers' compensation system. When we asked the assistant chief deputy commissioner if the Department of Insurance had attempted such a measurement, she responded that the department has drawn on the research of others, such as the studies cited in a draft issue paper prepared by the fraud division. However, the draft issue paper does not mention a methodology for measuring fraud. In fact, although the fraud division's issue paper is in the draft stage and does not present any conclusions on the merits of attempting to measure fraud in the workers' compensation system, it does contain several statements and quotes indicating the difficulty, the inconsistency, and even the futility of efforts to measure fraud.

Professionals who study fraud maintain that a systematic measurement of fraud is paramount to identifying the appropriate approach to controlling a fraud problem. In an issue paper on measuring fraud, the Coalition Against Insurance Fraud (coalition), an industry group primarily comprising entities associated with insurer and consumer groups, states that the most common rationale given for measuring fraud is a simple one: You need to know the extent of the problem to effectively

Professionals who study fraud maintain that a systematic measurement of fraud is paramount to identifying the appropriate approach to controlling fraud. Neither the fraud commission nor the insurance commissioner has made a meaningful attempt to measure how much and what types of fraud exist in the workers' compensation system.

solve it. In his 2000 book *License to Steal: How Fraud Bleeds America's Health Care System,* Malcolm Sparrow states that basic decision theory teaches the value of information when choosing between alternative courses of action. He further states that without knowing the true level of fraud, policymakers will likely make enormously costly errors by over- or underinvesting to control fraud. The coalition further points out that a secondary rationale for consistent measurement is to gain credibility through convincing consumers and legislators that fraud is a problem that requires remedies.

In the absence of systematic measurement, fraud can only be estimated, and some estimates can reflect the interests of the entities that provide the estimates. For example, in its draft issue paper, the fraud division points out that estimates of fraudulent workers' compensation claims range from 0.3 percent, as estimated by labor unions whose members receive benefits, to 20 percent, as estimated by employers that pay for the benefits.

Clearly, there are substantial difficulties in effectively measuring workers' compensation fraud. The coalition points out that in addition to the hidden nature of the crime, a major obstacle to measuring fraud is that it means different things to different people and that in a strict legal sense, fraud exists only when it has been so deemed by a court ruling. For example, no universally accepted distinction exists between abusing the workers' compensation system by exploiting lax rules or regulations and intentionally defrauding the system by wrongfully gaining or denying benefits. In addition, because workers' compensation benefits are paid by multiple payers, such as insurers and claims administrators, and neither currently reports on these transactions, there is no central claims payment database to aid in detecting systemwide fraud, as is found in a single-payer health care system such as California's Medicaid Assistance Program (Medi-Cal).

Other Entities Have Devised Ways to Measure Fraud and Noncompliance

Although determining the precise extent of fraud in the State's workers' compensation system may be impossible, two federal entities that sample available data have used certain mechanisms to successfully measure known fraud, benchmark the problem, and then monitor the results of fraud reduction activities. For example, the Internal Revenue Service (IRS), in a challenge similar to the one the fraud division faces with workers' compensation insurance, cannot know the exact extent of noncompliance or

fraud in the income tax collection system. However, the IRS has used audits of statistically selected tax returns to gain insight about the level of taxpayers' overall compliance with tax laws; understand the effectiveness of its regulations and programs; and design a strategy for enforcement audits that targets the returns most likely to be noncompliant, thereby putting the IRS's limited resources to their best use (see the text box).

Tools the Internal Revenue Service Plans to Use to Gain Information on Noncompliance and Fraud

- A representative sample of tax returns from the target year.
- A specially trained cadre of examiners.
- An assortment of case-building tools designed to verify as many reported items as possible without contacting taxpayers.
- A process for determining the level of audit, if any, a taxpayer return warrants and which items must be verified.
- An examination process that uses structured procedures and managerial reviews.

Because the IRS performed its last compliance review of taxpayers using returns filed for 1988, in 2002 it was planning to review another sampling of returns to evaluate taxpayers' current compliance with tax laws and regulations. In a June 2002 report on the plans of the IRS to conduct its new review, the United States General Accounting Office (GAO) indicated that the IRS set a strategic goal of ensuring taxpayer compliance but that it lacked current measures of voluntary compliance. The GAO advised that having such measures would help the IRS determine current compliance levels and identify steps likely to lead to improved compliance.

Likewise, Medicare fraud experts cite a review of medical payment transactions as an effective tool in identifying the extent and nature of fraud. In a September 2000 report to Congress on improper payments in the Medicare system, the GAO recognizes that given the sophisticated and dynamic nature of health care, fraud detection is not an exact science. No matter how sophisticated the fraud detection techniques used, it is unrealistic to expect to identify all fraud. However, according to the GAO report, the federal Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, used a variety of processes to measure improper payments. At the time of the report, the method the CMS used to identify improper payments focused on estimating Medicare payments that did not comply with the payment policies spelled out by laws and regulations but did not specifically attempt to identify potential fraud and abuse. The CMS was then working to improve its methodology to provide, in part, an average percentage of claims that were incorrectly paid or incorrectly denied. The ultimate goal of the improvements was a national improper-payment rate that the CMS planned to use to identify various "hot spots" of potential fraud throughout the country, increasing the CMS's ability to more effectively focus its program integrity efforts.

The Fraud Division Has Access to Data That Could Help It Assess the Extent of Workers' Compensation Fraud

According to the fraud division, although earlier antifraud efforts in California concentrated on fraud committed by workers, the fraud division and the insurance commissioner believe fraud committed by medical care providers and employers is more costly to the workers' compensation system and thus have assigned these types of fraud a higher priority in antifraud efforts. However, without a systematic measurement of the types of fraud and their magnitude, it is difficult to justify not only current activities but also any shift in focus. According to the fraud division chief, a lack of resources and expertise prevent the fraud division from measuring the extent and nature of fraud in the workers' compensation system and determining the effectiveness of its activities to deter fraud. However, he agrees that, with help, the fraud division could perform such analyses.

The Department of Insurance further told us that without detailed data on workers' compensation transactions, such as those that it expects may eventually be accumulated in the Workers' Compensation Information System of the Department of Industrial Relations (Industrial Relations), it is difficult to systematically identify payments that do not fit with normal payment patterns and that may signal potential fraud.

The fraud division could perform a statistically valid analysis to detect potential provider and claimant fraud in the form of indicators of actual or potential fraud for a large percentage of the State's workers' compensation insurance market using the data from as few as 37 insurers.

However, the Department of Insurance already has sources available to better detect and measure various types of fraud. For example, as part of the department that regulates the insurance industry, the fraud division has access to the payment databases of all companies licensed to sell insurance in California. According to the coalition, the data on closed workers' compensation claims in these databases include information useful in measuring fraud. Reports by the National Association of Insurance Commissioners for 2002 show that 37 insurers accounted for more than 84 percent of the California workers' compensation insurance market. As a result, using the data from as few as 37 insurers, the fraud division could perform a statistically valid analysis to detect potential provider and claimant fraud for a large percentage of the State's workers' compensation insurance market. The analysis could be in the form of indicators of actual or potential fraud, as described in the fraud division's guidelines and protocols for identifying and reporting potential fraud.

In addition, Industrial Relations conducts reviews of insurers, employers, and claims administrators to determine whether injured workers have received the benefits to which they are entitled.

Industrial Relations' Division of Labor Standards Enforcement (DLSE) reviews employers for compliance with the requirement to secure workers' compensation benefits for employees through its field visits to employers in industries with a history of noncompliance. Further, a program that the DLSE was to have implemented by January 1, 2003, but has not yet even been developed, would use data from the Employment Development Department and the Workers' Compensation Insurance Rating Bureau to identify employers that are unlawfully uninsured for workers' compensation benefits. All these activities could generate data that could be used to measure the extent of workers' compensation fraud and serve as a baseline against which to assess the effectiveness of subsequent efforts to reduce fraud. However, the fraud division has no plans to use these data to measure the nature and extent of fraud in the workers' compensation system.

No Overall Strategy Exists to Direct Statewide Workers' Compensation Antifraud Efforts

The fraud commission and the insurance commissioner have not collaborated to develop a statewide strategy for reducing fraud in the workers' compensation system. In fact, without knowing the extent of the problem that fraud represents to the workers' compensation system, it would be difficult to develop a strategy that is efficient and effective in identifying program participants' roles and responsibilities in managing statewide efforts to reduce fraud.

Strategic management is a process whereby managers establish a long-term direction, set specific performance objectives, develop strategies for achieving those objectives, and execute chosen action plans. An expert on fraud and fraud control at Harvard's John F. Kennedy School of Government has identified a fraud control model that includes the following characteristics: (1) commitment to routine, systematic measurement; (2) resource allocation for controls based on an assessment of the seriousness of the problem; (3) clear designation of responsibility for fraud control; (4) deliberate focus on early detection of new types of fraud; and (5) fraud-specific controls that intervene before payments are made. Invoking such an antifraud model would require the fraud commission and the insurance commissioner to design a strategy that addresses most of these components and ensures that fraud assessment funds are distributed to entities willing to carry out a statewide strategy.

Invoking an effective antifraud model would require that the fraud commission and the insurance commissioner design a strategy that addresses the necessary components and ensures that fraud assessment funds are distributed to entities willing to carry out a statewide strategy.

We asked the assistant chief deputy commissioner responsible for overseeing the Department of Insurance's antifraud programs about the insurance commissioner's efforts to work with the fraud

commission to establish a common strategy for fighting fraud within the workers' compensation system. She responded that the insurance commissioner views the program funded by the assessments levied on employers as one program that should have a common focus, as opposed to the many programs operated by the county district attorneys receiving fraud assessment funds, each with its own individual strategy and priorities. She stated that the insurance commissioner has communicated his priorities and strategies for antifraud efforts in the workers' compensation system through presentations made in public hearings conducted by the fraud commission and that these presentations appear in the hearing minutes. Although we found mention of broad priorities for the antifraud program in the insurance commissioner's numerous presentations to the fraud commission and legislative committees, and in press releases made throughout 2003, none of these presentations detailed his priorities for the use of fraud assessment funds.

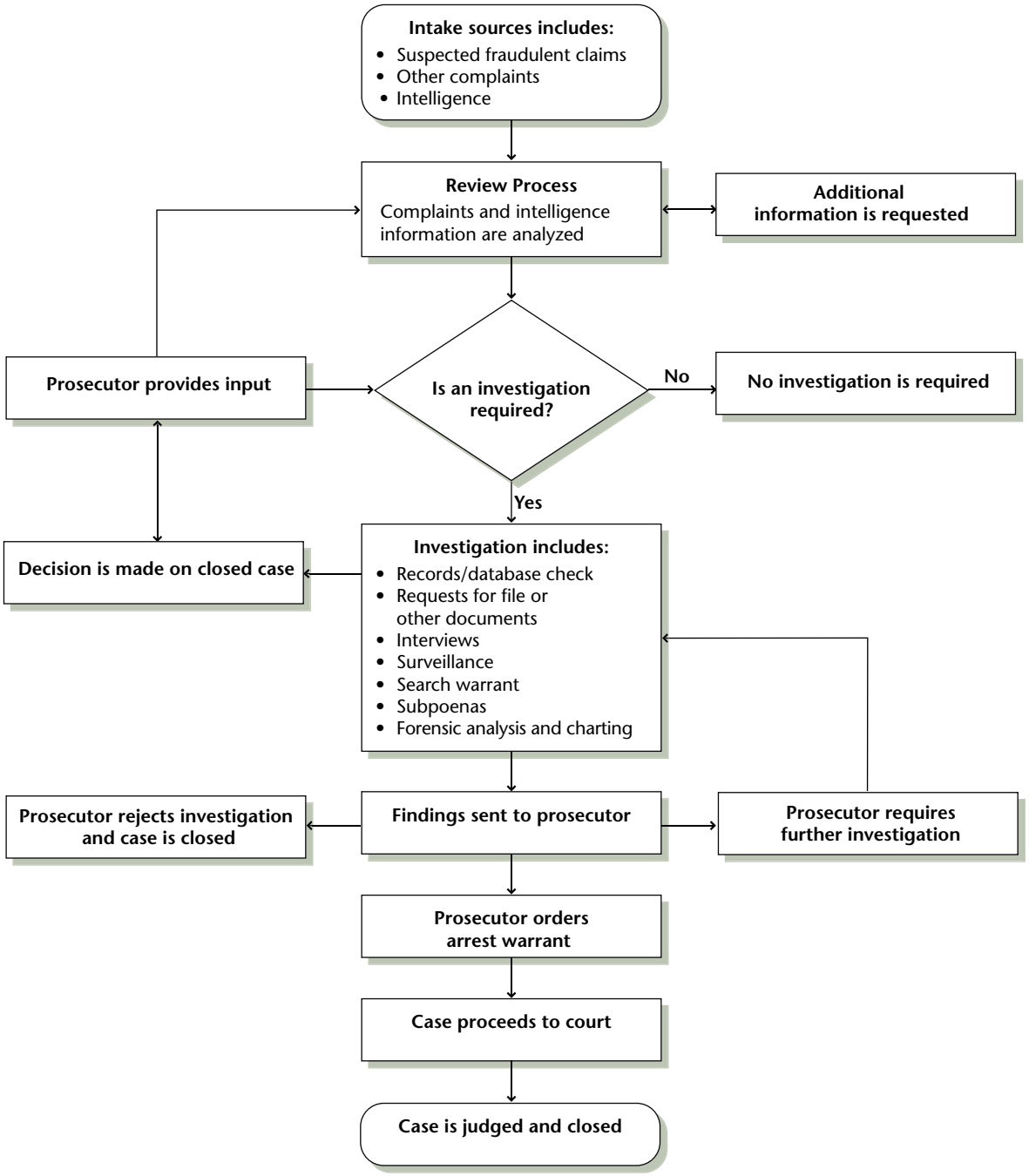
We also asked the assistant chief deputy commissioner how the insurance commissioner determines his priorities for the efforts to reduce workers' compensation fraud that are funded by the assessments. She stated that the insurance commissioner regularly meets with stakeholder groups to discuss workers' compensation issues. Priorities are influenced by stakeholders' input and are established with the intent of dedicating resources to high-impact cases, such as medical mills in which workers with real or feigned injuries are steered to specific medical providers who give them high-cost, long-term treatments. These high-impact cases typically result in higher amounts of fraudulent activity, affect more people, and serve as a larger deterrent to future fraud when successfully prosecuted.

The insurance commissioner's priorities for the fraud program are influenced by stakeholder input and are established with the intent of dedicating resources to high-impact cases, because these cases typically result in higher amounts of fraudulent activity, affect more people, and serve as a larger deterrent to future fraud when successfully prosecuted.

The current workers' compensation antifraud program has several participating groups, each with an important role to play in antifraud efforts. Figure 4 shows the current process of investigating and prosecuting fraud cases. However, as we discuss in Chapter 2, between September 2001 and December 2003, the fraud division did not submit 87 percent of the referrals it received to district attorneys for prosecution. In addition, half the fraud referrals it did submit for prosecution were for types of fraud that are not a high priority of the insurance commissioner. Moreover, county district attorneys do not necessarily follow the insurance commissioner's priorities when prosecuting workers' compensation fraud cases. For example, Los Angeles County received roughly 23 percent of the total annual assessment funds distributed to district attorneys in fiscal year 2002–03 but reported that 79 percent of its prosecutions in that same fiscal year were for claimant fraud, despite the

FIGURE 4

Fraud Division's Basic Steps in the Investigation Process



Source: Fraud Division, Department of Insurance.

fact that the insurance commissioner has stated that fraud by medical providers and employers is more costly to the workers' compensation system and thus a higher priority. For

fiscal years 2001–02 and 2002–03, claimant fraud accounted for 75 percent and 65 percent, respectively, of the prosecutorial activities of the county district attorneys that received fraud assessment funds in those fiscal years.

An important element of an antifraud program funded through assessments on employers is strategic planning that includes establishing systemwide goals, objectives, and priorities that are communicated to the participants in the program. Systemwide goals, objectives, and priorities can be broken down into regional elements to accommodate any unique regional fraud problems, but they must be attainable and measurable. In the case of the workers' compensation antifraud program, a stated objective of the fraud division to reduce costs by increasing investigations of high-impact cases by 10 percent or by increasing the number of fraud referrals by 10 percent could not be attained with certainty because the total extent of the fraud problem has not been measured. However, once fraud baselines are established using the techniques previously discussed, it would be possible to measure whether antifraud activities were effective in attaining such an objective.

The fraud division's practice of collecting and publishing discrete statistics of investigations, arrests, convictions, and restitution as measures of success of the program's efforts show only that some source of fraud may have been removed from the system, but does not reveal whether antifraud efforts have actually reduced the overall cost that fraud adds to the system.

Similarly, the fraud division's practice of measuring the success of the antifraud program by collecting and publishing discrete statistics of investigations, arrests, convictions, and restitution shows only that some source of fraud may have been removed from the system. The statistics do not reveal whether antifraud efforts have actually reduced the overall cost that fraud adds to the system. Nor does reporting the numbers of investigations and prosecutions reveal whether participants are focusing on antifraud priorities, because different types of cases require varying amounts of resources to investigate and prosecute, as do similar types of cases with different levels of complexity. Once baselines of the occurrence of fraud or potential fraud are established, however, the level of effort being exerted on high-priority types of fraud and their effects on reducing fraud can be measured. For example, the baselines—combined with subsequent periodic, systematic measurement of fraud using available data—would help determine the effectiveness of programwide objectives in reducing fraud in the workers' compensation system. Moreover, programwide goals and targeted levels of effort that are successful in achieving those goals can serve as criteria for allocating assessment funds to program participants.

We asked the chief of the fraud division if the fraud commission and the insurance commissioner had the authority to set statewide initiatives and priorities to be used as funding criteria

for the workers' compensation antifraud program. The chief told us that the fraud commission influences the scope and priorities of the program through the concerns voiced at its annual assessment meetings that the fraud division and participating district attorneys listen and respond to. However, the chief stated that the fraud commission is not the only entity that influences the antifraud program; the insurance commissioner and his staff are very involved with the program as well. Therefore, according to the chief, any programwide initiatives and priorities that might be used as criteria for awarding fraud assessment grants to county district attorneys would need to be shared by the insurance commissioner and the fraud commission. To demonstrate why such a shared view is necessary, the chief gave us the example of the fraud commission's consistent use of the arrest and conviction statistics the district attorneys present in their annual reports as measures of performance and a basis for awarding funding. The chief stated that, as a result, district attorneys may be influenced to increase their arrest and conviction numbers and may not be as willing to work on medical provider cases that can take more time and resources but are one of the insurance commissioner's goals. Nevertheless, the fraud commission and the insurance commissioner have thus far not collaborated in developing a statewide strategy in the form of a plan containing their consensus of the goals, objectives, actions, and performance targets necessary to reduce fraud in the workers' compensation system.

The fraud commission and the insurance commissioner have thus far not collaborated in developing a statewide strategy in the form of a plan containing their consensus of the goals, objectives, actions, and performance targets necessary to reduce fraud in the workers' compensation system.

The Fraud Commission and the Insurance Commissioner Conduct Activities to Obtain Input From the Workers' Compensation Community

On several occasions, the fraud commission and the insurance commissioner, sometimes working with the fraud division, have held forums that allowed for stakeholder input on fraud in the workers' compensation system. For example, the fraud commission annually holds a public meeting before it determines the aggregate assessment level. The meeting gives district attorneys participating in the program an opportunity to describe their antifraud efforts, and the fraud commission opens the floor to other stakeholders wishing to make a statement before the aggregate assessment is determined. For example, in the meeting held in December 2003, both the insurance commissioner and a former fraud division chief spoke to the fraud commission about the ongoing need for the antifraud effort.

In November 2003, the California District Attorneys Association and the Department of Insurance held a roundtable discussion at which they met with members of the fraud commission to inform and educate them on issues related to workers' compensation fraud.

The agenda for the November 2003 roundtable discussion, which the fraud division provided us, was limited to background discussions of the workers' compensation antifraud program and the funding process, upcoming legislative issues, and referrals of suspected fraud; topics on the agenda did not include the extent of fraud in the system or a systemwide strategy to combat it. In addition, the fraud division had no record of any conclusions or recommendations reached as a result of the session. According to the manager of the fraud division's local assistance unit, no minutes were kept of the session and no formal action resulted. Furthermore, the manager of the local assistance unit told us that before this meeting, the last roundtable discussion held was in 1999.

The workers' compensation antifraud program could benefit from a committee similar to one that provides advice to the fraud division, and to other public and private entities, on ways to coordinate the investigation, prosecution, and prevention of automobile insurance fraud. Established by the Insurance Code, the committee comprises representatives from several stakeholder groups, with the following explicit purpose and goals:

Entities Represented on the Auto Fraud Advisory Committee

- Fraud division
- Department of Justice
- Department of Motor Vehicles
- Division of Investigation of the Department of Consumer Affairs
- California Highway Patrol
- Bureau of Automotive Repair
- Parole and Community Services Division of the Department of Corrections
- State Bar of California
- Medical Board of California
- Local law enforcement agencies
- Insurers
- Labor organizations with members in the automotive repair business
- Board of Chiropractic Examiners

- Recommend to the fraud division and other public and private sector agencies ways to coordinate the investigation, prosecution, and prevention of automobile insurance claims fraud.

- Assist the fraud division in implementing the goal of reducing the frequency and severity of fraudulent automobile insurance claims by specific percentages in urban and rural areas within two years.

- Ensure that the prevention, investigation, prosecution, and data collection efforts of the fraud division are efficient, cost-effective, and in line with similar efforts undertaken by law enforcement agencies and insurers.

- Make recommendations to be included in the fraud division's annual report.

A workers' compensation fraud advisory committee with broad membership and a purpose and goals similar to those just listed would increase

the ability of the fraud commission and the insurance commissioner to ensure that statewide antifraud efforts are efficient and cost-effective.

The Workers' Compensation Fraud Advisory Committee has not met since October 2002 because of low attendance at committee hearings, budget limitations, and management changes at the Department of Insurance.

The assistant chief deputy commissioner stated that such an advisory committee does exist—the Workers' Compensation Fraud Advisory Committee (fraud advisory committee). Although the composition of the fraud advisory committee is not mandated by statute or regulation, it typically has comprised stakeholders in the workers' compensation system, including representatives from the insurance industry, prosecutors, investigators, and the Department of Insurance. However, the fraud advisory committee has not met since October 2002 because of low attendance at committee hearings, budget limitations, and management transitions at the Department of Insurance. The chief of the fraud division stated that he intends to reestablish the fraud advisory committee with a broader representation of stakeholders. He also stated that the prelude to the first meeting of the reformed committee will be the roundtable discussions with the fraud commission, the California District Attorneys Association, and the Department of Insurance scheduled for later this year.

Once elected, the insurance commissioner did assemble one advisory panel and one task force on a temporary basis to provide input on the status of various issues surrounding the workers' compensation system, including fraud. However, the advisory panel's report to the insurance commissioner, issued in February 2003, did not address fraud. In contrast, the workers' compensation task force (task force), in its February 2003 report to the insurance commissioner, advised that legislation that took effect in 2003 (Chapter 6, Statutes of 2002) amended the Insurance Code to allow fraud assessment funds to be used to investigate and prosecute unlawfully uninsured employers. The task force report also warned that the rising costs in the workers' compensation system, combined with the worsening economy, provided an increased risk of fraud being perpetrated by employees and employers. It recommended that the insurance commissioner remind insurers of their responsibility to maintain a special investigative unit and to refer all valid cases involving alleged fraud, including those of fraudulent denial of workers' compensation benefits, to the appropriate authority. The task force also recommended that the insurance commissioner, in concert with Industrial Relations and district attorneys, establish a task force to analyze the economic and technical feasibility of developing a statewide database of workers' compensation medical provider billing data that could be used to enhance

In his February 2004 plan for workers' compensation reform, the insurance commissioner stated that the Department of Insurance was restructuring its fraud and investigative units to improve coordination efforts and prioritize workers' compensation cases.

fraud detection and injury prevention. Finally, the task force recommended that the Department of Insurance conduct outreach to the workers' compensation community to inform them that fraud of any kind in the workers' compensation system will not be tolerated and should be mitigated through early proactive management.

In response to this and other input, the insurance commissioner, in his February 2004 plan for workers' compensation reform, stated that the Department of Insurance is restructuring its fraud and investigative units to improve coordination efforts and prioritize cases of fraud in the workers' compensation system. The insurance commissioner also said that the department is improving its working relationship with district attorneys and other state, federal, and local law enforcement agencies, with an emphasis on information sharing.

ANNUAL FUNDING LEVELS FOR ANTIFRAUD EFFORTS ARE NOT BASED ON DOCUMENTED NEEDS

The fraud commission is statutorily empowered to identify problems associated with efforts to combat workers' compensation fraud and provide funding to enable the fraud division and county district attorneys to most effectively fight that fraud. However, the fraud commission reaches its funding decisions without adequate knowledge of the extent and nature of the problems caused by fraud in the workers' compensation system or the effects of prior years' efforts to reduce fraud. In addition, the fraud commission lacks detailed information regarding the plans of the fraud division and county district attorneys for using the funds in the upcoming year to reduce fraud in the workers' compensation system. In fact, at the fraud commission's December 2003 meeting, one member voiced her concern that the commission was voting on the fraud assessment for fiscal year 2004–05 without having enough information to make an informed decision.

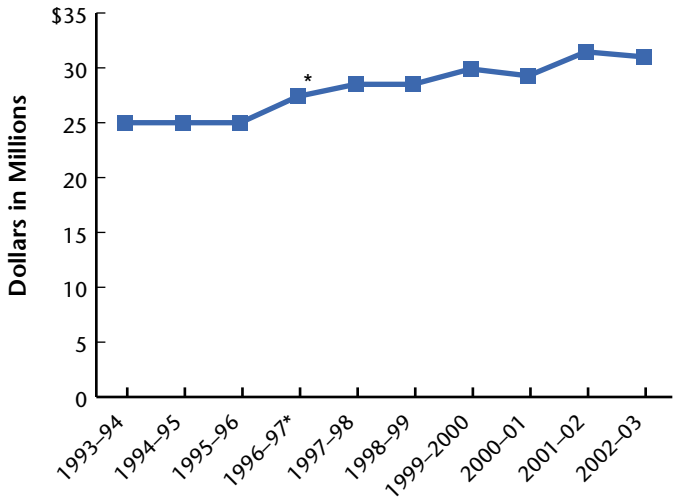
Without the necessary information, the fraud commission cannot ensure that the aggregate assessment it authorizes each year is needed or is adequate to sufficiently address reducing fraud in the workers' compensation system. Further, there is little assurance that the funds it assesses against California's employers—averaging approximately $30 million for each of the past five years—have been used effectively to reduce the amount of fraud and thereby reduce the overall cost that fraud adds to the workers' compensation system.

The Fraud Assessment Commission Bases the Annual Assessment on Previous Funding Levels to Ensure Continuity of the Program

Without any meaningful measurement of the extent to which fraud drives up workers' compensation system costs, and without the ability to evaluate past efforts to deter fraud, the fraud commission bases the annual aggregate assessment on prior years' assessments. According to one member of the fraud commission, one of the motivations behind the funding decision is to levy an assessment that allows both the fraud division and the county district attorneys to maintain their current level of effort in pursuing workers' compensation fraud. As shown in Figure 5, consistent with this explanation, the aggregate assessment has been relatively constant for the past five years, ending with fiscal year 2002–03.

FIGURE 5

Annual Aggregate Assessment Amount Levied by the Fraud Commission



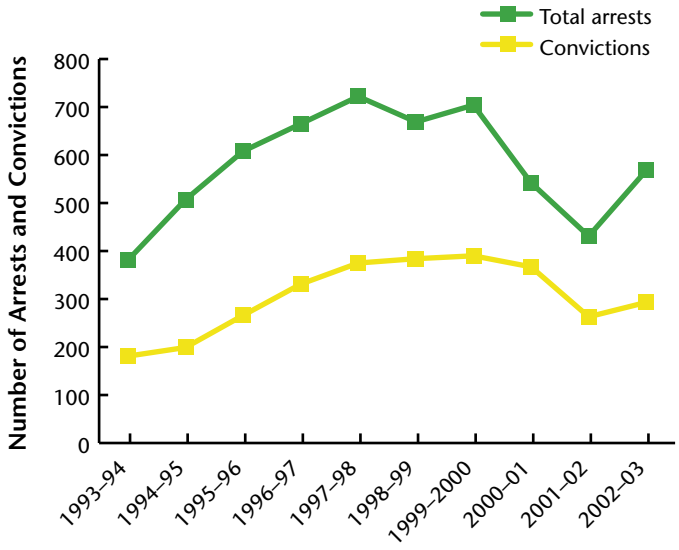
Source: Fraud division's Annual Program Reports.

* Amount includes $2.4 million in restitution funds directed to district attorneys.

As shown in Figure 6 on the following page, antifraud activities funded by fraud assessments generally resulted in increased numbers of arrests and convictions for the first six years of the program. However, despite relatively stable assessments over the past five years, arrests and convictions have declined in two of the past three years. Although these numbers do not tell the whole story because certain types of fraud cases

FIGURE 6

Number of Arrests and Convictions in the Workers' Compensation Fraud Program



Source: Fraud division's Annual Program Reports.

take longer to investigate and prosecute, without basing the aggregate assessment on a baseline measurement of the amount of fraud in the system and the level of funding necessary to fight it effectively, the fraud commission and the insurance commissioner have no way of demonstrating that the program is cost-effective and is lowering the overall cost of fraud to the workers' compensation system.

The Fraud Assessment Commission Has Limited Information When Determining the Annual Aggregate Assessment

Because the assessment is not based on the extent of fraud in the system, the process adopted by the fraud commission to arrive at the total funding needed to fight fraud is flawed. The fraud commission determines the aggregate assessment without reviewing any detailed information about the district attorneys' past performance in reducing fraud and without obtaining a proposal from the fraud division specifying how it plans to spend the grant award during the coming year.

The fraud commission convenes a meeting each December to discuss the amount it will assess California's employers to fund the investigation and prosecution of fraud in the workers'

The fraud commission determines the aggregate assessment amount without reviewing any detailed information about the district attorneys' past performance in reducing fraud and without obtaining a specific proposal from the fraud division as to how it plans to spend the grant award during the upcoming year.

compensation system. According to the fraud division's local assistance manager, the fraud commission holds this meeting in mid-December so the assessment can be incorporated into the governor's budget. One member of the fraud commission stated that because of the timing of this meeting, the fraud commission has limited information on which to base its decision. Both the fraud division and the fraud commission indicated that the primary source of data used by the fraud commission in making its decision is a preliminary budget report supplied by each district attorney. Each county district attorney interested in participating in the workers' compensation antifraud program is asked to submit a projected budget in December for review by the fraud commission. The fraud division collects these budgets and provides them, along with a summary estimate of the total amount of funding requested by district attorneys in their respective budgets, to the fraud commission.

The fraud division asks that these budgets include a summary of personnel services costs, operating expenses, and equipment as well as an outline of the activities to be undertaken by the district attorney, such as the number of projected investigations, prosecutions, and type of caseload. For example, the overview of one budget included a request for additional trial support staff and a full-time legal position to investigate and prosecute employers that fail to secure workers' compensation benefits for their employees, and it mentioned that several such cases were being prosecuted. This budget also described some of the outreach projects carried out in the past year and the district attorney's desire to continue those types of activities. However, other than anecdotally discussing the cases the district attorney anticipated would be concluded, the budget did not cover the number of cases the district attorney planned to prosecute or how many and what types of outreach projects would take place over the next year. Without this type of detailed information, the fraud commission has a limited ability to ascertain the true resource needs of each county district attorney in fighting fraud.

Although the fraud commission does receive the district attorneys' budgets before it holds its hearing to decide on the annual fraud assessment, the district attorneys' reports outlining the activities they completed with the prior year's funding are not required until January, nearly one month after the fraud commission has made its determination. These reports contain various types of statistics, including each district attorney's respective numbers of investigations, arrests,

and prosecutions. Despite providing some useful information, the district attorneys' reports are not linked to the objectives they describe in their applications for fraud assessment funds, and the district attorneys do not report their progress in achieving their objectives. Therefore, the reports do not help the fraud commission better understand the effectiveness of each district attorney in fighting fraud. As a result, even if the fraud commission were to receive the district attorneys' reports before its December meeting, the information in the reports would be of little use in determining whether the amount the fraud commission assessed in the prior year was actually having the desired effect. Armed with reports that lack adequate information, the fraud commission has no performance measures to use when determining whether its aggregate assessment is appropriate.

The fraud commission also does not receive adequate information from the fraud division regarding its activities before making a decision regarding what the aggregate fraud assessment should be. Rather than submitting a budget outlining its funding needs, the fraud division made a PowerPoint presentation to the fraud commission at its December 2003 meeting, describing its efforts and some of the results it has achieved in fighting fraud. As part of this presentation, the division chief indicated that for fiscal year 2002–03, the fraud division opened 827 new cases and submitted 257 cases to county district attorneys for prosecution. However, our review of the referrals entered into the fraud division's database from September 2001 through December 2003—a period that included all of fiscal year 2002–03—indicates that the fraud division submitted only 233 cases to district attorneys for prosecution during the period. Moreover, such statistics do not contain information specific enough for the fraud commission to know whether these activities are cost-effective in reducing workers' compensation fraud or to determine the appropriate level of assessments for the coming year.

The commission plans to ask the fraud division to present its budget at the December 2004 fraud assessment meeting because the fraud commission does not have a clear picture of where the money is being spent or where it is needed.

According to the chair of the fraud commission, the commission plans to ask the fraud division to present its budget at the December 2004 fraud assessment meeting because the fraud commission does not have a clear picture of where the money is being spent or where it is needed. Without such information, the fraud commission has little evidence to gauge whether the fraud assessment funds the fraud division receives are being used effectively and thus whether its aggregate assessment is appropriate.

The Fraud Assessment Commission Has Limited Authority to Hold the Fraud Division or District Attorneys Accountable for Their Antifraud Efforts

The fraud commission has the final decision over the aggregate amount to be levied against employers, and once the assessment has been decided on, the fraud commission further decides how the assessed funds should be allocated between the fraud division and the grants awarded to participating county district attorneys. According to state law, after certain incidental and administrative costs to run the program are deducted, at least 40 percent of the annual aggregate fraud assessment must be set aside for grants to district attorneys and 40 percent must be provided to the fraud division. The fraud commission has discretion as to how the remaining 20 percent is divided for these two purposes. Therefore, although the fraud commission decides the amount of the aggregate fraud assessment, it has little ability to hold the fraud division or district attorneys accountable for how they spend the funds. For example, if the fraud commission were inclined to give either the fraud division or the district attorneys less funding, its discretion would be limited to a maximum of 20 percent of the aggregate amount assessed. One commissioner told us that she would like to see the fraud commission have more discretion as to how it divides the funds, instead of being restricted by this formula. This commissioner believes that having this additional flexibility would allow the commission to better hold the fraud division and district attorneys accountable. In fiscal year 2002–03, the fraud division received 45 percent of the funds and the district attorneys received 55 percent.

One commissioner told us that she would like to see the fraud commission have more discretion as to how it divides the funds, instead of being restricted by a formula—believing the added flexibility would allow the commission to better hold the fraud division and district attorneys accountable.

PROCEDURES TO DETERMINE THE MOST EFFECTIVE DISTRIBUTION OF FRAUD ASSESSMENT FUNDS LACK ACCOUNTABILITY

Both the fraud commission and the insurance commissioner, with the assistance of a review panel and the fraud division, are involved in awarding grant funds to the district attorneys participating in the workers' compensation antifraud program. For fiscal year 2003–04, the fraud commission consented to a distribution totaling $17.4 million in grants of fraud assessment funds to district attorneys. However, fraud division staff and members of the review panel—both of whom are responsible for evaluating district attorneys' applications and recommending how much grant funds each should be awarded—do not use standard criteria to evaluate the applications or document the

rationale they use in reaching their respective recommendations for distributing the funds. Further, none of the criteria used includes measures of performance that would allow the fraud division staff, the review panel, the insurance commissioner, and the fraud commission to make a more informed decision on the most effective distribution of fraud assessment funds, as the law requires. As shown in Appendix A, the grant awards approved by the fraud commission differ from the funds requested in fiscal year 2003–04 for all but three of the 36 county district attorneys that applied for grants. In addition, controls intended to restrict the use of grant funds for county administrative costs are not always effective. Moreover, the fraud division and the review panel do not base their recommendations for the distributions of fraud assessment funds to participating district attorneys exclusively on an evaluation of the district attorneys' applications for the funds, as called for in Department of Insurance regulations. Finally, although the legal division for the Department of Insurance indicated that open-meeting requirements may apply, the review panel held a key portion of its July 2003 meeting to decide on district attorney funding amounts in a closed session.

The Review Panel Has Not Implemented Procedures That Demonstrate Assessment Funds Are Distributed Where They Will Be Most Effective in Fighting Fraud

Rather than using standardized criteria and justifying their choices, the individuals responsible for making funding recommendations to the fraud commission regarding the amount to be distributed to each participating district attorney use their own individual criteria and do not document the reasons for their recommendations.

The process that exists for allocating fraud assessment funds to district attorneys is based on the individual judgments of the members of the review panel, not on an established evaluation method. Rather than using standardized criteria and justifying their choices, the individuals responsible for making funding recommendations to the fraud commission regarding the amount to be distributed to each participating district attorney use personal criteria and do not document the reasons for their decisions.

When determining how to allocate funds to county district attorneys, the insurance commissioner convenes a five-member review panel that, with the assistance of the fraud division, collects and reviews the applications submitted by district attorneys who would like to participate in the workers' compensation antifraud program. The application contains several elements, as required by Department of Insurance regulations, including various performance statistics, the district attorney's plans for using the funds, and a description of ongoing investigations and prosecutions. The panel members

review the applications and hold hearings to listen to individual presentations and further question the district attorneys about their plans for the grant funds and the results attained from using past grant funding. Ultimately, the review panel decides on a grant award to recommend for each participating county district attorney and forwards its recommendations to the insurance commissioner. Based on the recommendations of the review panel and with the advice and consent of the fraud division, the insurance commissioner makes his determination on the most effective distribution of the funds. Before the funds are distributed to the district attorneys, the insurance commissioner forwards his decision to the chair of the fraud commission and receives written consent.

According to the review panel members we spoke to, each member of the panel has his or her own criteria for reviewing the applications and making a recommendation for the funding to be distributed to each county district attorney. The panel members do not share their criteria or rationale with the applicant district attorneys or the other review panelists. Thus, the final decision reached by the review panel is based on a consensus of separate opinions, rather than on standard criteria.

A former review panel member told us that looking at performance statistics and expenditure plans in isolation does not give a complete picture of a district attorney's effectiveness.

According to one former and one current member of the review panel, one reason the panel has adopted this decision-making process is that it is difficult to quantify the effectiveness of a district attorney's efforts in fighting fraud. A former review panel member told us that looking at performance statistics and expenditure plans in isolation does not give a complete picture of a district attorney's effectiveness. For example, a conviction in a case of fraud by a medical provider might take years to investigate and prosecute, while a conviction in another type of fraud case might take only a matter of months. Thus, basing a funding award strictly on performance statistics is of limited value. The fraud division is currently pursuing efforts to develop a standardized assessment method that could be used to evaluate county district attorney performance, as discussed at the end of the chapter.

Before fiscal year 2002–03, review panel members were asked to complete a score sheet rating the application of each county district attorney on a number of factors, including performance, qualifications, and program strategy. After completing the score sheets, the review panel submitted them to the fraud division, which tallied the scores and ranked each application. Fraud division staff then distributed this list to the review panel

members so they could see the aggregate scores and ranking. According to fraud division staff, this rating system is no longer used because the fraud commission now holds its meetings in an open forum, and the division did not want the ratings of individual district attorneys' strengths and weaknesses to be made a part of the public record. However, by not establishing standardized criteria with which to evaluate county district attorneys' applications for antifraud program funding and failing to document how panel members reach their collective recommendations for distributing those funds, the review panel is leaving itself open to the perception that the process may not be equitable.

The Fraud Division Does Not Document Its Reasons for Recommendations to the Review Panel for Funding Grants to District Attorneys

Because the review panel and fraud division staff that advise the fraud commission and insurance commissioner do not document the reasons for their decisions on the grant award amounts they recommend individual district attorneys receive, the decision-making process is not replicable and lacks accountability.

According to its regulations, the Department of Insurance is required to place the chief of the fraud division or a designee on the review panel. The fraud division assists the chief in his role as a panel member and makes its recommendation to the review panel for an amount to award each county district attorney. Like the review panel, the fraud division does not use standardized criteria when evaluating the applications; instead, according to the fraud division chief, it bases its recommendations on reviews conducted by its staff. However, because the review panel and fraud division staff that advise the fraud commission and insurance commissioner do not document the reasons for their grant award recommendations, the decision-making process is not replicable and thus lacks accountability.

According to the fraud division's workers' compensation bureau chief, the fraud division management instructs staff to develop the recommendations by reviewing the applications and assessing the adequacy of the county district attorneys' proposals. Management also asks the chief investigators at the fraud division's nine regional offices to review the applications of the district attorneys from their regions with whom they work directly. Following their review, the chief investigators prepare brief narratives containing their opinions of the county district attorneys' plans and past performance and their funding recommendations. Fraud division staff and management then meet to discuss their individual reviews of the applications and the chief investigators' narratives, ultimately arriving at a final funding recommendation.

Although we found some evidence that fraud division staff review and chief investigators comment on the district attorneys' applications, management in the fraud division does not document how it uses that information to arrive at its recommendations for funding granted to district attorneys. According to the fraud division's workers' compensation bureau chief, these recommendations act only as a starting point for the funding discussions at the review panel hearing and are sometimes altered by the members of the review panel before the final recommendation is forwarded to the insurance commissioner. We understand that these recommendations are not the final word of the review panel, but they do provide advice and may exert some influence over the final funding recommendations. In fact, as shown in Appendix A, for 19 of the 36 county district attorneys that the review panel considered for funding in fiscal year 2003–04, the review panel agreed with the fraud division's recommendations. Without documenting how it arrives at these recommendations, the fraud division leaves itself open to the perception that the process may not be fair.

Controls Intended to Restrict County District Attorneys' Use of Grant Funds Are Not Always Effective

Decision makers who evaluate applications from county district attorneys for fraud assessment grants and recommend funding for these grants do not always ensure that the county district attorneys follow Department of Insurance regulations intended to limit charges of county indirect costs, such as those costs for county administrative services, to grants of fraud assessment funds.

Decision makers who evaluate applications from county district attorneys for fraud assessment grants and recommend funding for the grants—the fraud division, review panel, insurance commissioner, and fraud commission—do not always ensure that the county district attorneys follow Department of Insurance regulations intended to limit charges of county indirect costs, such as those costs for county administrative services, to grants of fraud assessment funds. Specifically, the regulations give county district attorneys three options for charging county indirect costs to workers' compensation fraud assessment grants: (1) they can charge indirect costs in compliance with cost allocation plans required by the federal Office of Management and Budget (OMB) Circular A-87 for federal domestic assistance programs—a plan that is negotiated with federal agencies without input from the fraud commission or the insurance commissioner; (2) they can charge up to 10 percent of salaries and wages, excluding the costs of employees' benefits and overtime; or (3) they can charge up to 5 percent of total direct program costs.

We reviewed the applications from 10 of the counties that received the largest grants for fiscal year 2003–04 and found that the district attorneys for Alameda and San Bernardino counties

and the City and County of San Francisco did not include in their grant applications whether or how they proposed to charge indirect costs to the grants they were applying for, and audited expenditure reports for the grants do not show these costs separately. As a result, decision makers who reviewed these three applications could not have known whether the indirect costs the district attorneys planned to charge to their grants met with the regulations for the program. The grants to the three county district attorneys accounted for about $2.5 million, or nearly 15 percent of the funds awarded to district attorneys for fiscal year 2003–04.

The program's regulations do not appear to provide the restrictions on charges of indirect costs that the fraud commission expects.

Moreover, the program's regulations do not appear to provide the restrictions on charges of indirect costs that the fraud commission expects. For example, the district attorney's office for Los Angeles County indicated in its fiscal year 2003–04 grant application that it planned to charge its county indirect costs to its grant at a rate of 43 percent of the costs of salaries and wages charged to the program—a rate it claimed was in compliance with OMB Circular A-87 and, therefore, with Department of Insurance regulations. However, as we discuss in Chapter 2, the annual independent audit reports submitted by county district attorneys do not ensure that county district attorneys have used fraud assessment funds in accordance with program requirements. As a result, the fraud commission and the fraud division do not know whether Los Angeles County's indirect cost percentage does indeed comply with program regulations.

Under its proposed budget, the Los Angeles County district attorney's office charges the antifraud program funds directly for the costs of the salaries, wages, and benefits for staff who work in the program. The district attorney's office calculates its charges for most of the support services for those employees, identified as operating costs, by multiplying its indirect cost rate times the costs of salaries and wages. Unlike most of the other county district attorneys in the antifraud program whose budgets we reviewed, the Los Angeles County district attorney does not separate the support services that can be directly identified to the employees who work on the program, and whose salaries are directly charged to the program, from the support costs that cannot be separately identified and must be indirectly charged through an allocation process. Instead, it charges most of its operating costs to the antifraud program using its indirect cost rate.

Using its indirect cost rate of 43 percent, Los Angeles County's proposal for fiscal year 2003–04 included almost $1.5 million for allocated operating costs, out of a total proposed budget of

just over $6.3 million. In addition to allocated costs, Los Angeles County charges fraud assessment grants for travel, training, audit fees, and parking to arrive at total operating costs of $1.55 million, representing slightly more than 44 percent of the salaries and wages charged directly to the antifraud program. To identify the effect of the Los Angeles County district attorney's method for charging costs, we attempted to recalculate its total operating costs using the two other options allowed by Department of Insurance regulations for calculating indirect costs. However, as previously discussed, the information provided by Los Angeles County did not allow for such a recalculation because it did not separately identify direct program costs from indirect costs.

Therefore, we compared Los Angeles County's operating expenses to those charged by district attorneys in two other high-cost counties, Santa Clara and San Diego. These two county district attorneys separately identify their direct and indirect costs and calculate their indirect costs using the option that allows 10 percent of salaries, excluding benefits and overtime. Our comparison reveals that the ratio of Los Angeles County's proposed total operating expenses to its costs for salaries and wages was roughly twice those of these other high-cost counties: Santa Clara County at 21 percent of salaries and wages and San Diego County at 20 percent of salaries and wages. Using the third option to calculate indirect costs—5 percent of total direct costs—resulted in even lower indirect costs for Santa Clara and San Diego counties.

Our comparison revealed that the ratio of Los Angeles County's proposed operating expenses to its costs for salaries and wages was roughly twice that of two other high-cost counties.

The primary difference between the three options is that the formula for the second and third options includes a cap on indirect costs that is defined by Department of Insurance regulations. In contrast, the first option, which allows the use of indirect cost rates under OMB A-87, is based on an indirect countywide cost rate that is negotiated and approved by a federal agency, without any input from the fraud commission or the fraud division. Consequently, the restrictions present in the second and third options are, for the most part, absent from the first option, producing, in the case of the indirect costs proposed by the Los Angeles County district attorney, a very different result.

In its December 2003 meeting to determine the aggregate assessment for the workers' compensation antifraud program for fiscal year 2004–05, members of the fraud commission questioned the representative from the Los Angeles County district attorney's office on the high indirect cost rate. The representative responded

that the indirect costs in the district attorney's proposal included office space, phones, desks—everything that needs to be provided to a group of employees except salaries and benefits. He further stated that the indirect cost rate complied with federal guidelines and that the Los Angeles County board of supervisors had instructed the district attorney's office to apply this rate to the workers' compensation fraud assessment grant. The representative stated that under Los Angeles County's understanding of the program's regulations, the county was entitled to charge a 43 percent indirect cost rate, and that the fraud commission should change the regulations if it felt this rate was unacceptable. The minutes of this meeting did not contain any discussion that led to a resolution of the issue. Despite the apparent disagreement between the fraud commission and the Los Angeles County district attorney about the appropriate amount of indirect costs that should be charged to the fraud assessment grant, Los Angeles County was awarded $4.3 million for fiscal year 2003–04—roughly 25 percent of the total funds available to county district attorneys that year.

Recommendations for Some of the Grant Funding Received by District Attorneys Are Not Based Exclusively on Evaluations of Their Applications

The fraud division and the review panel do not base their recommendations on the distribution of fraud assessment funds to participating district attorneys exclusively on evaluations of the district attorneys' applications for the funds, as called for in the regulations. The grant awards made to district attorneys are made up of two components: (1) a base allocation derived from a formula delineated in the Department of Insurance regulations and (2) a program award based on the specifics of each district attorney's plan to investigate and prosecute fraud.

Apparently based on legal advice received in the early days of the program, the fraud division believes that the review panel must recommend base allocations as long as the county sends in a completed application within the time limit prescribed.

The fraud division believes that the review panel must grant base allocations without evaluating the content of each district attorney's application, as long as the county sends in a completed application within the time limit prescribed. According to a manager in the fraud division, this belief is apparently based on legal advice the fraud division received in the early days of the program. Moreover, a section of Department of Insurance regulations states that if the review panel finds that the county district attorney has failed to respond adequately to the required items, the panel may recommend funding at the base allocation level. However, this section of the regulations contains an erroneous reference. Section 2698.57 states, "if the county plan fails to respond

adequately to the required items as specified in sections 2693.6 and 2693.7, the panel may recommend funding at the district attorney's base allocation level." However, sections 2693.6 and 2693.7 do not exist in the Department of Insurance regulations. Therefore, if these are the criteria used by the panel to recommend funding levels, we are unsure of the basis for the recommendations.

Furthermore, another section of the regulations is quite clear that both the base allocations and the program awards to district attorneys must be based on evaluations of the counties' plans included in the applications for funding. Because of the fraud division's interpretation of the regulations and its instructions to the review panel, 50 percent of the funds available for district attorneys, or more than $7 million for fiscal year 2002–03, was recommended for distribution by the review panel based merely on the fact that the counties had completed the required portions of their applications.

The Review Panel Does Not Always Comply With Open-Meeting Requirements When Developing Its Funding Recommendations

Before 2002, the review panel's process of developing funding recommendations for county district attorneys included holding closed hearings at which the district attorneys would present specific information about various aspects of their workers' compensation antifraud programs, including planned and ongoing investigations. Members of the review panel told us that having these meetings closed to the public enabled them to ask the district attorneys pointed questions about ongoing investigations and resource allocations without jeopardizing the district attorneys' confidentiality requirements. The review panel members believe the freedom to ask these questions enabled the panel to determine a more effective allocation of resources.

However, beginning in September 2002, the review panel began holding its meetings in open session because the fraud division indicated to the fraud commission that the review panel's closed meetings might be in violation of open-meeting laws. Even though legal counsel for the Department of Insurance is not certain that the Bagley-Keene Open Meeting Act (Bagley-Keene) applies to the review panel, the fraud division requested that the panel discontinue conducting closed hearings. Our own legal counsel is of the opinion that the review panel is subject to the Bagley-Keene provisions and would require a specific exemption from the act to conduct part of its hearings in closed session to

Contrary to the Department of Insurance legal counsel's advice that the review panel's closed meetings might be in violation of the Bagley-Keene Open Meeting Act, in its July 2003 meeting the review panel appeared to determine its final funding recommendation in closed session.

discuss criminal investigations that are by law confidential. The panel members we spoke with said they are reticent, in an open-meeting forum, to ask district attorneys questions about ongoing investigative efforts for fear of hampering their investigations. Thus, the review panel's ability to obtain the information it needs to effectively distribute the funding is limited.

Although the Department of Insurance legal counsel is uncertain whether Bagley-Keene provisions apply, the fraud division has instructed the review panel and the district attorneys to proceed as though the provisions do apply. Nevertheless, in its July 2003 meeting, the review panel appeared to determine its final funding recommendations for fiscal year 2003–04 in closed session. We reviewed the minutes of this meeting and found that after the district attorneys had made their presentations, but before the panel members began discussing specific funding recommendations, the panel took a break. Once the panel members reconvened the meeting, they had arrived at final funding recommendations, which was passed by a majority vote. One member of the review panel confirmed that during this break, the panel members had discussed the funding recommendations and arrived at final decisions in a closed session.

The Fraud Division Is Developing Performance Measures to Help It Evaluate Its Own Effectiveness and That of the County District Attorneys in Reducing Fraud

In a recent memorandum, the chief of the fraud division stated that the division is working to establish a set of performance metrics to better evaluate the effectiveness of the fraud division and participating district attorneys in reducing the overall cost of workers' compensation fraud. The fraud division's workers' compensation bureau chief told us that the division was in the process of amending an existing consultant contract to help develop performance measures. However, at the time of our review, the fraud division and its consultant had not yet developed the performance measures sufficiently for us to evaluate them or comment on their potential effectiveness for the purposes listed in the fraud division chief's memorandum.

We contacted two members of the fraud commission to discuss the commission's position on developing a method of measuring the performance of the fraud division and the district attorneys that could be used in awarding grants of fraud assessment funds. One fraud commission member stated that there would be limited value in implementing such a system using the

performance statistics currently collected. According to this commission member, merely looking at the number of arrests, even if they are segregated by the type of case, is not enough to determine whether one district attorney is more effective than another. Therefore, any measures of performance using the type of data the fraud division currently collects, such as arrest statistics, would be of limited use. However, we believe additional information on performance, such as success in attaining the stated objectives of the fraud commission and the insurance commissioner, would be beneficial to the fraud commission in evaluating the performance of county district attorneys and the fraud division.

The chair of the fraud commission stated that the fraud commission has not really delved into the subject of accountability and funding for the fraud division. He added that this year would be the first time the fraud commission would be asking the fraud division to account for its activities. He stated that to hold the fraud division accountable, the fraud commission could reduce the fraud division's funding, but he did not believe such an action would really be effective.

RECOMMENDATIONS

To better determine the assessment to levy against employers each year for use in reducing fraud in the workers' compensation system, the fraud commission and the insurance commissioner should direct the fraud division to measure the nature and extent of fraud in the workers' compensation system. To establish benchmarks to gauge the effectiveness of future antifraud activities, these measures should include analyses of available data from insurers and state departments engaged in employment-related activities, such as Industrial Relations and the Employment Development Department. In addition, the insurance commissioner should consider reactivating an advisory committee comprising stakeholders focused on reducing fraud in the workers' compensation system to contribute to the data analyses, provide input about the effects of fraud, and suggest priorities for reducing it. This advisory committee should meet regularly and in an open forum to increase public awareness and the accountability of the process.

Given the nature and extent of fraud in the system, the fraud commission and the insurance commissioner and his staff should design and implement a strategy to reduce workers'

compensation fraud. The strategy should be systemwide in scope and include goals, objectives, priorities, and measurable targets that can be effectively communicated to the fraud division and the county district attorneys participating in the antifraud program. Efforts to achieve the strategy targets should be both a condition for receiving awards of fraud assessment funds and a measure of how well the fraud division and the county district attorneys pursue the systemwide objectives. The strategy should clearly define the roles and responsibilities of the participants in antifraud activities.

To gather the information necessary to make its decision on the annual amount to be assessed from employers to fight fraud in the workers' compensation system, the fraud commission should take the following steps:

- Revamp its decision-making process so that it includes the best information available, including (1) the results of the Department of Insurance's analyses of the nature and extent of fraud in the workers' compensation system, once they are completed; (2) analysis of the effectiveness of efforts by the fraud division and district attorneys in the prior year to reduce fraud in accordance with their respective program objectives; and (3) any newly emerging trends in fraud schemes that should receive more attention.

- Request an annual report from the fraud division that outlines (1) its prior year objectives linked to measurable outcomes and (2) its objectives for the ensuing year, together with estimates of the expenditures the fraud division needs to make to accomplish those objectives.

- Request, in addition to the information currently required of each county district attorney planning to participate in the antifraud program, a report listing the district attorney's accomplishments in achieving the goals and objectives outlined in the prior year's application and the goals and objectives for the ensuing year. The report should also include the estimated cost of the grant year's activities to achieve the district attorney's goals and objectives and a description of how those goals and objectives align with the program goals described by the fraud commission and the insurance commissioner.

If the fraud commission believes that altering the funding formula from the statutorily required levels—under which 40 percent of fraud assessment funds are automatically awarded to both the fraud division and the district attorneys—would

increase accountability over the use of antifraud program funds, it should encourage legislation that would allow it more discretion in how these funds are distributed.

To better ensure that fraud assessment funds are distributed to district attorneys so as to most effectively investigate and prosecute workers' compensation fraud and increase their accountability in using the funds, the fraud commission and the insurance commissioner should take the following steps:

- Develop and implement a process for awarding fraud assessment grants that provides consistency among those making funding recommendations by incorporating standard decision-making criteria and a rating system that supports funding recommendations.

- Include in the decision-making criteria how well the county district attorneys' proposals for using fraud assessment funds align with the strategy and priorities developed by the fraud commission and the insurance commissioner, as well as the district attorneys' effectiveness in meeting the prior year's objectives.

- Document the rationale for making decisions on recommendations for grant awards.

- Reevaluate the Department of Insurance regulations pertaining to how indirect costs are charged to fraud assessment grants to determine whether the regulations provide the desired amount of control. The fraud commission and the insurance commissioner should also seek changes in the regulations if required and ensure that all county district attorneys that apply for fraud assessment grants disclose their methods of charging indirect costs.

- Change the past policy of awarding the base portion of fraud assessment grants to county district attorneys exclusively on whether they submitted a completed application by the required deadline and instead, make recommendations for total grant awards, including the base allocations, on evaluations of county district attorneys' plans that include how they will use the funds, as required by Department of Insurance regulations.

- Determine whether the Bagley-Keene provisions apply to the review panel's meetings to recommend fraud assessment grants to county district attorneys and, if they do, seek a

specific exemption for discussions of portions of the county district attorneys' applications for grant awards that include confidential criminal investigation information. The parts of the meeting discussing recommendations for district attorney funding levels should remain open to the public, however, and the fraud commission and the insurance commissioner should ensure that the review panel complies with the requirements of Bagley-Keene.

- Continue current efforts to establish performance measures to use in evaluating the effectiveness of the fraud division and participating district attorneys in reducing workers' compensation fraud. The measures could also assist in (1) determining the appropriate amount of funds to be assessed and divided between the fraud division and grants for county district attorneys and (2) determining recommendations for grant awards to the county district attorneys and the fraud division. ■

CHAPTER 2

Lacking Adequate Strategic Planning, the Fraud Division Has Not Met All Its Responsibilities for the Workers' Compensation Antifraud Program

CHAPTER SUMMARY

Because the Department of Insurance's Fraud Division (fraud division) has not conducted adequate strategic planning for its workers' compensation antifraud activities, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation fraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys. The fraud division pays for its workers' compensation antifraud activities using its share of the funds from the fraud assessment levied against California employers. Over the five years ending fiscal year 2002–03, the fraud division's portion of the fraud assessment funds averaged more than $13 million per year.

Comprehensive strategic planning would require that the fraud division (1) take specific steps to identify all its responsibilities for the workers' compensation antifraud program, (2) establish and prioritize goals and define the necessary objectives to accomplish them, (3) establish timelines and action plans for completing each objective and allocate the available resources based on its priorities, and (4) define benchmarks for each activity that can be used to evaluate performance outcomes and reset targets. The fraud division has largely left all these tasks undone.

Because it has not used a strategic approach to planning, the fraud division dedicates too few resources to the noninvestigative activities required to meet its statutory responsibilities. For example, the fraud division has made little attempt to conduct the research necessary to measure the magnitude of fraud by type—research that could guide the fraud division's approach and measure its actions and effectiveness in reducing the fraud problem. Further, the fraud division has not developed the information on fraud it requires to prepare reports for individuals and entities overseeing the program, such as the insurance commissioner, the Legislature, and the Fraud Assessment Commission (fraud commission). However, the fraud

division's ability to successfully identify goals and objectives is somewhat limited because, as discussed in Chapter 1, the fraud commission and the insurance commissioner have not established a statewide strategy for the antifraud program.

Although the fraud division dedicates the majority of its workers' compensation resources to investigating suspected workers' compensation fraud, it does not submit a large percentage of the referrals it receives to county district attorneys for prosecution. Moreover, for many referrals of suspected high-impact fraud—the types of fraud that the insurance commissioner believes are the most costly to the workers' compensation system—the fraud division closes the case without performing an investigation because of a lack of evidence, or it investigates the case but does not refer it to a district attorney for prosecution.

Further, the fraud division does not adequately monitor district attorneys' use of workers' compensation fraud assessment funds. Each district attorney participating in the antifraud program must provide the fraud division with an annual financial audit report that includes certification that the district attorney used the fraud assessment funds in compliance with applicable laws and regulations and the conditions contained in the application for a fraud assessment grant. However, the fraud division does not consistently enforce the requirement that the audit reports include the required certification; therefore, many do not, leaving the fraud division with no assurance that fraud assessment funds awarded to district attorneys are used in accordance with program requirements.

An audit unit within the Department of Insurance also performs reviews of district attorneys' use of workers' compensation fraud assessment funds that have resulted in the detection and recovery of questionable expenditures, but the audit unit's coverage of district attorneys is limited because it does not have sufficient staff to audit all district attorneys that receive workers' compensation fraud assessment grants on a regular basis.

THE FRAUD DIVISION HAS NOT CONDUCTED STRATEGIC PLANNING TO ENSURE THAT IT MEETS ITS RESPONSIBILITIES

As a result of poor strategic planning, the fraud division has not met all its statutory responsibilities in areas that include research, grant administration, and auditing insurers' compliance with

reporting suspected fraud. Strategic planning is a long-term, future-oriented process of assessment, goal setting, and decision making that maps an explicit path between the present and a vision of the future. Essential elements of sound strategic planning include analyzing the environment, defining a mission and goals, establishing priorities among goals and allocating resources, and measuring actual performance against predefined benchmarks (see the text box).

Essential Elements of Strategic Planning

- Identify responsibilities, strengths, weaknesses, problems, and opportunities.
- Define the mission and formulate goals consistent with the mission.
- Identify key issues relating to the mission and the planned activities.
- Establish priorities among the goals and allocate resources accordingly.
- Define the objectives necessary to achieve each stated goal.
- Establish timelines and action plans to complete each objective.
- Define benchmarks or targets for each appropriate activity.
- Measure the results of planned operations against the benchmarks to evaluate performance and reset targets as necessary.

A strategic plan should focus on outcomes or benefits derived from the efforts expended rather than on the efforts themselves. A successful planning process provides many benefits to both the agency and the clients the agency serves. Strategic planning improves an agency's ability to anticipate and accommodate the future by identifying issues, opportunities, and problems. Good planning also enhances decision making at both the operational and executive management levels because it focuses on results, provides information to guide managers in making resource allocation decisions, and establishes a basis for measuring the success of the agency's activities. Finally, the fundamental concept underlying strategic planning is its dynamic nature. The planning process is not a one-time project that, once completed, remains static. Instead, it should be an iterative process that is refined and refocused as performance is measured, targets are reset, and new information becomes available.

The Fraud Division's Business Plan Does Not Adequately Define Its Responsibilities

Fraud Division's Mission Statement

To protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud and to reduce the overall incidence of insurance fraud through antifraud outreach to the public, private, and governmental sectors.

Source: Fraud Division Business Plan (revised January 2004).

Instead of a strategic plan, the fraud division has developed a business plan. The business plan contains the fraud division's mission, a single goal—to be the best consumer protection agency in the nation and enforce workers' compensation fraud laws vigorously, effectively, and fairly—and three objectives relating specifically to workers' compensation fraud and one applicable to all types of fraud.

We discovered that many of the fraud division's noninvestigative functions are neither included in the fraud division's mission statement nor well

Goal and Objectives Defined in the Fraud Division's Business Plan

Goal:

- To be the best consumer protection agency in the nation and to enforce workers' compensation fraud laws vigorously, effectively, and fairly.

Objectives directly related to workers' compensation fraud or to fraud in general:

- To reduce overall workers' compensation costs to employers by increasing the investigations of high-impact cases by 10 percent over the prior year.
- To decrease the cost of workers' compensation insurance in California by working with insurance companies to increase the number of insurance fraud referrals to the fraud division by 10 percent.
- To implement a pilot project to improve outreach efforts in the workers' compensation insurance industry by educating the roofing and construction industry on detecting workers' compensation fraud schemes, including premium fraud.
- To ensure that quality cases are assigned and to preclude the creation of a case backlog, the fraud division will increase by 10 percent the number of suspected fraudulent claims reviewed by supervisors for investigation or disposition.

defined in its business plan and, as a result, are understaffed or nonexistent. As shown in the text box on the previous page, the fraud division's mission speaks only to investigations, arrests, and outreach and does not include its noninvestigative functions, which are meant to ensure that investigations are carried out effectively and efficiently. We reviewed the fraud division's business plan (revised January 2004) and found that although the fraud division recognizes that its organizational purpose is to provide all investigative and support services necessary to implement and manage the workers' compensation antifraud program, the business plan does not specifically define what that means. For example, it makes no mention of its advisory role to the Legislature and the fraud commission, or to the research function needed to obtain the information necessary to guide its approach in fighting fraud and to provide reliable advice. In addition, although the fraud division's business plan recognizes that its local assistance unit oversees the workers' compensation grant program that provides fraud assessment funds to participating county district attorneys, its responsibility as a grant administrator is not specifically defined.

The Fraud Division Has Not Established the Goals and Objectives Necessary to Meet All Its Responsibilities

In its January 2004 revised business plan, the fraud division identified some key issues for the workers' compensation antifraud program, but it did not develop sufficient goals or objectives to address the key issues or to remedy problems it recognized. In fact, the fraud division's business plan has only one goal and four objectives that either specifically address workers' compensation fraud or address fraud in general (see the text box). However, neither its goal nor its objectives are specific enough to provide sufficient direction for the fraud division's antifraud efforts.

In the section of its business plan that analyzes its performance, the fraud division lists key limitations in implementing the workers' compensation antifraud program but does not adequately identify goals and objectives for addressing each limitation. For example, the fraud division acknowledges that

some of the external criticisms of the division include that it is not investigating all cases, that case investigations take too long, and that the fraud division does not provide a return on investment. However, the fraud division did not adopt or amend any goals, objectives, or actions to address these issues in its business plan, particularly, an objective or action to measure the magnitude of the problem of fraud in the workers' compensation system or to develop a way to quantify the results of its antifraud efforts so as to demonstrate their value.

Moreover, the fraud division states in its business plan that the insurance industry is not consistently referring suspected fraud claims to the division and is actively opposing new or modified regulations regarding that requirement. In fact, the fraud division acknowledges that the insurance industry might take legal action to suspend enactment of permanent regulations. Although one of the fraud division's objectives speaks to working with insurers to increase the number of fraud referrals they submit, the action plan to accomplish this objective does not address the need to resolve any differences between the fraud division's definition of what constitutes fraud and its standards regarding the evidence necessary to successfully investigate and prosecute fraud and the insurers' concerns in those areas.

The business plan is silent regarding how the fraud division can use its special investigative audit unit to improve insurers' compliance with requirements for reporting suspected fraud.

The business plan is silent regarding how the fraud division can use its special investigative audit unit to improve insurers' compliance with requirements for reporting suspected fraud. The fraud division identified as a weakness that, because of budget constraints and limited resources, its special investigative audit unit would not be able to audit all insurers in the foreseeable future. Even though it has the authority to charge insurers for the costs of reviewing their special investigative units, the fraud division did not plan a way to minimize or overcome this weakness, and, as we discuss in Chapter 3, it does not review a significant number of insurers.

Some of the objectives that the fraud division has included in its business plan for the workers' compensation antifraud program will not necessarily accomplish their stated outcomes even if the objectives are achieved. For example, the fraud division has established an objective to reduce overall workers' compensation costs to employers by increasing by 10 percent the number of investigations of high-impact cases—those suspected fraud cases that include multiple suspects, involve a medical provider or attorney, or result in large losses—over the prior year. However,

Some of the objectives that the fraud division has included in its business plan for the workers' compensation antifraud program will not necessarily accomplish their stated outcomes even if the objectives are achieved.

merely investigating more suspected high-impact fraud cases than were investigated in the prior year will not necessarily produce the outcome of reducing the overall cost that fraud adds to the system and is paid for by employers. Furthermore, this objective cannot produce measurable results. The objective aims to reduce cost drivers in the workers' compensation system, but because the fraud division has not attempted to measure the magnitude or economic cost of fraud in the workers' compensation system or the effect of its antifraud efforts, it cannot measure any reductions in fraud that its efforts may prompt.

The fraud division's stated objective of decreasing the cost of workers' compensation insurance by working with insurers to increase the number of referrals of suspected fraud is similarly flawed. Simply increasing the number of referrals will not necessarily decrease the cost of workers' compensation insurance. In fact, many of the referrals the fraud division currently receives do not result in prosecution by district attorneys.

Finally, the fraud division's ability to set goals and objectives is limited because, as we discussed in Chapter 1, the fraud commission and the insurance commissioner have not established a statewide strategy and defined roles and responsibilities of the participants in the workers' compensation antifraud program that would better support the annual assessment levied on employers and ensure the most effective use of these funds. As a result, the insurance commissioner's priority for the fraud division to pursue more high-impact cases presents another challenge to fraud division management, because the district attorneys are not required to pursue the insurance commissioner's priorities as a condition for receiving fraud assessment funds. Therefore, to avoid using limited resources on cases that will not be prosecuted, the fraud division must, to some degree, conform its activities to the priorities of the district attorneys who prosecute its cases, not necessarily to the insurance commissioner's priorities.

The Fraud Division Does Not Allocate Its Resources to Meet Its Responsibilities or Establish Adequate Performance Measures

Although the fraud division recognizes that its resources are limited, it does not allocate the resources it does have to minimally meet all of its responsibilities. For example, the fraud division acknowledges in the January 2004 revision of its business plan that it does not have the budget or personnel resources to investigate all cases or audit all insurers for compliance with fraud reporting requirements. It also acknowledges that its managers need to continue to learn to use all resources—capital,

Although the fraud division recognizes that it does not have unlimited resources, it does not allocate the resources it does have to meet all of its responsibilities.

information, time, and people. Moreover, the fraud division's local assistance unit—the unit responsible for administering various fraud assessment grants to county district attorneys—has such limited resources allocated to it that it uses the fraud division's research specialist to assist in gathering and compiling information from county district attorneys and to provide what information is available on the use of fraud assessment funds to investigate and prosecute fraud. As a result, the research specialist is not available to conduct the type of research needed to identify the nature and extent of workers' compensation fraud and develop ways to establish baselines that can be used to measure the effectiveness of antifraud efforts. Also, as we discuss in Chapter 3, the special investigative audit unit does not have adequate staff to perform the necessary number of audits to provide assurance that insurers are complying with fraud-reporting requirements, another of the fraud division's responsibilities. Thus, the fraud division is not dedicating sufficient resources to its noninvestigative functions to even minimally accomplish them. In fact, in the section in the business plan covering budget and resource analyses, the fraud division indicates a need for increased staff resources to perform additional investigations but fails to recognize a need for more resources to perform these noninvestigative activities.

In addition, the fraud division does not adequately measure its effectiveness in reducing fraud or its performance in meeting its goal and objectives. For example, it has not developed a meaningful way to measure the effect of its activities on the overall cost of fraud to the workers' compensation system—that is, the return on investment of the fraud assessment funds. The fraud division's bureau chief for workers' compensation told us that the fraud division evaluates its performance and its effectiveness in reducing fraud by using the statistics it compiles for its annual reports and for reports to the fraud commission of the actual caseload it works and the results of that caseload. For instance, the fraud division annually reports to the fraud commission and the Legislature on the number of referrals it has investigated and the number of referrals it has submitted to district attorneys for prosecution. Although these statistics may give some indication of the sources of fraud that might be taken out of the system, they do not indicate whether the fraud division's efforts have lowered the overall cost that fraud adds to the system, as would the techniques we describe in Chapter 1. The chief of the fraud division acknowledged that a baseline measurement for monitoring performance and justifying cost could be made but added that the fraud division has neither the expertise nor the resources necessary to conduct the needed analysis.

Likewise, as stated in its business plan, the fraud division measures its success in educating employers in the roofing and construction industries by using activity measures such as counting the number of these employers attending fraud division seminars. However, the fraud division does not develop the types of measures that would determine whether its outreach efforts have reduced the overall incidence of insurance fraud, as the fraud division defined in its mission statement. Such a measure might consist of statistical trends on the number of fraud referrals it received for a targeted industry or reduction in the type of fraud that the fraud division's outreach was focused on, collected both before and after the outreach effort.

Another objective in the business plan is to increase the number of referrals reviewed by supervisors to ensure that quality cases are assigned to investigators and to preclude the development of a case backlog. However, the measurements it has defined to determine its success in achieving this objective include keeping tallies of referrals received, referrals backlogged, and referrals that contain errors, as well as tracking the number of insurers and others it contacts regarding errors in referrals and performing quarterly reviews of pending referrals. Such activities do not incorporate steps that the fraud division supervisors could use to ensure that cases assigned for investigation are of high quality. Instead of focusing its actions on why many referrals are of low quality and correcting the problem, the fraud division has chosen to track a variety of activities that will do nothing to improve the quality of its referrals.

THE FRAUD DIVISION DOES NOT MEET ALL ITS NONINVESTIGATIVE RESPONSIBILITIES

It is clear from the statutes that created the workers' compensation antifraud program that the Legislature intended for the fraud division to play an important advisory role in decisions regarding the level of funding and the direction of the fraud reduction efforts.

Not only does the fraud division substantially ignore noninvestigative functions in its business plan, but it also fails to allocate enough resources to these activities to ensure that it at least minimally meets its responsibilities. For example, it is clear from the statutes that created the workers' compensation antifraud program that the Legislature intended the fraud division to play an important advisory role in decisions regarding the level of funding and the direction of the fraud reduction efforts. Sections of the Insurance Code state that the fraud division will provide advice to the fraud commission and the insurance commissioner, report to the governor through the insurance commissioner's annual report on the economic impact of fraud, and make recommendations for reducing

insurance fraud. These sections show that the Legislature and governor look to the fraud division for research regarding the measurement of fraud and fraud reduction activities in the State. However, the fraud division has not conducted such research to provide advice and information as required, nor does it maintain a research function capable of doing so.

Rather than draw on the skills listed in his job description, such as developing databases containing suspected fraud claims, identifying trends in insurance fraud, and designing statistical and survey techniques and training staff in their use, the fraud division's research specialist spends the majority of his time working in a unit that administers local assistance grant funds.

For example, the fraud division does not always use its research specialist to study workers' compensation issues and has not gained the capability to conduct the research activities necessary to measure the extent and nature of workers' compensation fraud, evaluate the effectiveness of the fraud division's and district attorneys' efforts to deter fraud, and develop the information mandated by law. Rather than drawing on the skills listed in the job description, such as developing databases containing suspected fraud claims, identifying trends in insurance fraud, and designing statistical and survey techniques and training staff in their use, the fraud division's research specialist spends the bulk of his time working in a unit that administers local assistance grant funds and serving as the coordinator of the workers' compensation antifraud program in which county district attorneys participate. The research specialist is working in the local assistance unit because that unit is not adequately staffed to perform all its duties.

According to the fraud division's bureau chief for workers' compensation, the reason the division is not measuring performance and performing research is that the division does not have the expertise and resources necessary to conduct such analysis. As of February 2004, the fraud division moved one staff person from another unit to the local assistance unit to take over the local assistance work that was being performed by the research specialist.

As we mentioned earlier, two objectives relating to the fraud division's business plan seek to reduce the overall cost of the workers' compensation system to employers, but because it has not attempted to measure the economic cost of fraud in the workers' compensation system, the fraud division cannot measure the effects of its antifraud efforts. In fact, the fraud division has taken the position that measuring fraud is too difficult. In October 2003, it drafted an issue memorandum in which it recognized that knowing the scope of workers' compensation fraud is valuable to choosing wisely among alternate courses of action and allocating resources effectively. However, the memo primarily discussed the reasons why

estimating the amount of workers' compensation fraud is difficult. As for trying to measure its own effectiveness in deterring fraud, in March 2004, during the course of our audit work, the fraud division initiated the process of amending an existing consultant contract to begin working on a set of metrics to measure the effect of its antifraud efforts and refine its business plan. However, at the time of our review the fraud division and its consultant had not yet developed the performance measures for us to evaluate them or comment on their potential effectiveness. The failure of the fraud division to conduct the research necessary to identify the value of the workers' compensation antifraud program it administers deprives the fraud division of information it needs to plan and evaluate its operations and leaves it without the means to demonstrate its worth in reducing workers' compensation fraud.

The failure of the fraud division to conduct the research necessary to identify the value of the workers' compensation antifraud program it administers deprives the fraud division of information it needs to plan and evaluate its operations and leaves it without the means to demonstrate its worth in reducing workers' compensation fraud.

The fraud division also does not report information required by law, including estimates of the economic value of insurance fraud by type of fraud and recommendations of ways to reduce insurance fraud. When the fraud division fails to report all the data elements the law requires, the Legislature, governor, and fraud commission are not provided with the information they need to make well-informed decisions regarding the proper amount and use of the workers' compensation fraud assessment.

The annual workers' compensation antifraud program reports (program reports) the fraud division produces to inform the Legislature and fraud commission on the progress of the antifraud program do not provide required information regarding the antifraud program's expenditures, search warrants issued, and number of parties involved in fraud arrests and prosecutions. Although by law the program reports must contain the funding the fraud division received and a detailed breakdown of how it used the funds, the fraud division ignores these and other requirements and largely limits its reports to the allocations made to the district attorneys, the number of arrests and prosecutions, and the number of convictions and the names of those convicted. Table 1 shows the items the fraud division is required to report and whether it complied with that requirement in fiscal years 2000–01 and 2001–02.

TABLE 1

Requirements for Reporting by the Fraud Division to the Legislature and Fraud Commission

Reporting Requirement	Compliance for Fiscal Years 2000–01 and 2001–02
All allocations, distributions, and expenditures of funds	Partially
Number of search warrants issued	No
Number of arrests and prosecutions, and the aggregate number of parties involved in each	Partially
Number of convictions and the names of all convicted fraud perpetrators	Yes
Estimated value of all assets frozen, penalties assessed, and restitutions made for each conviction	Partially
Any additional items necessary to fully inform the fraud commission and the Legislature of the fraud-fighting efforts financed through this section	Partially

Sources: Insurance Code and fraud division Program Reports for fiscal years 2000–01 and 2001–02.

Moreover, the fraud division did not ensure that the information it contributed to the insurance commissioner's annual reports to the governor was complete in 2001 and 2002. As shown in Table 2 on the following page, it did not report on seven of 10 categories specifically required during both years. In fact, the fraud division fully reported only two of the 10 mandated categories of information in 2001, and just one in 2002.

A LARGE PERCENTAGE OF THE FRAUD DIVISION'S REFERRALS DO NOT RESULT IN PROSECUTIONS

We found that 87 percent of the workers' compensation referrals the fraud division received between September 2001 and December 2003 were not submitted to district attorneys for prosecution.

From our review of the fraud division's case management database, it appears that the fraud division could more effectively manage its investigative efforts. For example, as shown in Figure 7 on page 69, we found that 87 percent of the workers' compensation referrals the fraud division received between September 2001 and December 2003 were not submitted to district attorneys for prosecution. However, the fraud division's investigators did not charge time to all these referrals. Of the 7,891 referrals[1] it closed and did not submit to district attorneys for prosecution, the fraud division spent time

[1] Of these referrals, the fraud division closed and referred 641 to other entities for investigation—479 to district attorneys and 162 to other entities—according to the fraud division's database.

TABLE 2

Requirements for Reporting by the Fraud Division for the Insurance Commissioner's Annual Report to the Governor

Reporting Requirement	Fulfilled? 2001	Fulfilled? 2002
Number of cases reported to the fraud division	Yes	Partially
Number of cases rejected for which an investigation was not initiated by the fraud division and the reasons for not investigating them	No	No
Number of cases prosecuted in cooperation with other government licensing agencies governed by the Business and Professions Code	No	No
Number of cases prosecuted as a result of the insurance commissioner's assessment of funds from insurers under Insurance Code, Section 1872.7, for the costs of administration and operation of the fraud division	No	No
Estimate of the economic value of insurance fraud by type of insurance fraud	Partially	Partially
Recommendations of ways to reduce insurance fraud	No	No
Summary of activities in pursuing fraud reduction with the following parties: • Insurance companies • Department of Motor Vehicles • California Highway Patrol • Licensing agencies governed by the Business and Professions Code • Department of Insurance • Local and state law enforcement agencies • Employers that are self-insured for workers' compensation	No	No
Basic claims information, including trends of payments by type of claim and other claim information generally provided in a closed-claim study	No	No
Summary of activities in pursuing a reduction in fraudulent denials and payments of compensation	No	No
Number and types of cases investigated and prosecuted with workers' compensation fraud assessment funds	Yes	Yes

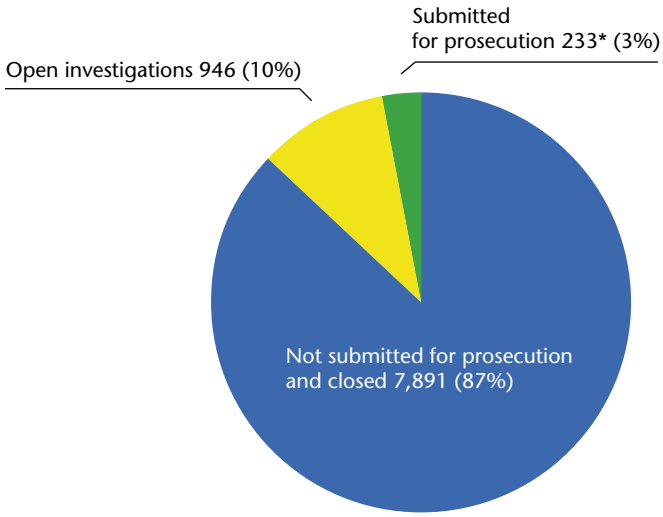
Sources: Insurance Code, 2001 Annual Report of the Insurance Commissioner, and the fraud division's information submitted for the 2002 Annual Report.

investigating 1,362. Similarly, the fraud division did not spend time investigating all of its open cases and cases it submitted to district attorneys for prosecution[2]. As shown in Figure 8 on page 70, during the same period, fraud division investigators spent more than 16 percent of their investigative hours on the 1,362 cases it closed and did not submit to the district attorneys. Excluding open investigations that have yet to be submitted for prosecution, fraud division investigators spent roughly one-third of their recorded hours on the 1,362 cases that were closed and not submitted to district attorneys for prosecution and two-thirds of their hours on the 232 cases that were submitted.

[2] Fraud division investigators charged time to 634 of the 946 open cases and 232 of the 233 cases it submitted to district attorneys for prosecution.

FIGURE 7

Outcome of Referrals the Fraud Division Received From September 2001 Through December 2003



Source: Fraud division's case management database.

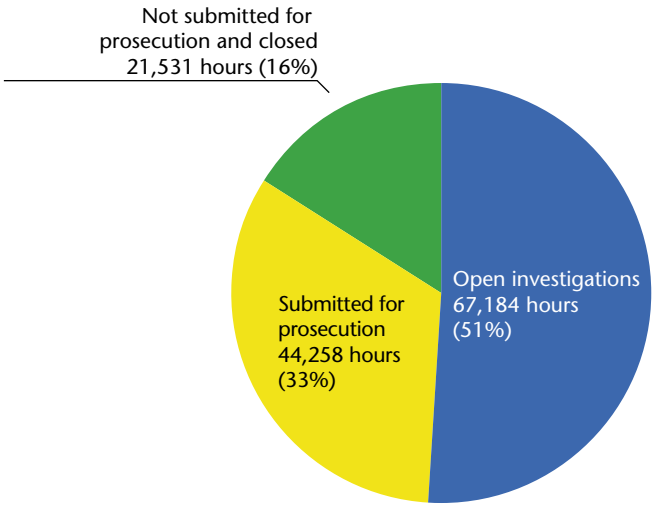
* Of the 233 referrals submitted for prosecution as of December 22, 2003, 28 were rejected by district attorneys.

Therefore, it is reasonable to assume that nearly one-third of the hours charged to the open investigations, or roughly 22,400 hours for the period we reviewed, will probably be spent on cases that the fraud division will not submit to district attorneys for prosecution.

Although its database indicates that the fraud division submitted only 3 percent of its workers' compensation fraud referrals for prosecution, it did not look at this issue in more depth. Based on the large portion of referrals that the fraud division reports are closed because of insufficient evidence, it appears that the quality of suspected fraud referrals the fraud division receives from insurers is not high enough to allow for successful investigations. Moreover, no objective listed in the fraud division's business plan addresses improving the quantity and quality of the evidence the fraud division receives supporting insurers' fraud referrals or increasing the number of referrals it submits for prosecution. In fact, one of its objectives—to increase the number of referrals it receives by 10 percent—seems to be at odds with these statistics. To further this objective, the Department of Insurance promulgated new emergency regulations in September 2003 meant, in part, to increase the number of workers' compensation

FIGURE 8

Outcome of Hours Fraud Division Investigators Spent on All Referrals From September 2001 Through December 2003


Not submitted for prosecution and closed 21,531 hours (16%)
Open investigations 67,184 hours (51%)
Submitted for prosecution 44,258 hours (33%)

Source: Fraud division's case management database.

fraud referrals it receives by 10 percent over the prior three-year average. However, according to the fraud division's database, it does not investigate or submit to district attorneys the majority of the referrals it currently receives.

The assistant chief deputy commissioner stated that the fraud division emphasizes the insurance commissioner's initiative of focusing on high-impact referrals—those suspected fraud cases that include multiple suspects, involve a medical provider or attorney, or result in large losses—through its referral prioritization system.

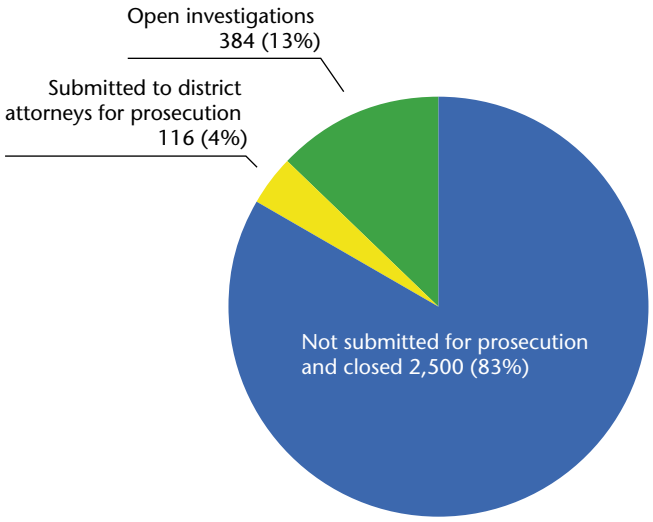
Furthermore, the fraud division has not adequately monitored and managed its referral and investigation caseloads to determine its success in focusing on the stated priorities of the insurance commissioner and fraud division. The assistant chief deputy commissioner stated that the fraud division emphasizes the insurance commissioner's initiative of focusing on high-impact referrals—those suspected fraud cases that include multiple suspects, involve a medical provider or attorney, or result in large losses—through its referral prioritization system. The assistant chief deputy commissioner stated that the priorities are influenced by stakeholder input and are established with the intent of directing resources to high-impact cases involving multiple suspects or a large number of victims that will serve as a deterrent to future fraud.

According to the insurance commissioner, he approved the new priorities and strategies for the workers' compensation antifraud program in April 2003. In response, the fraud division's workers' compensation bureau chief stated that the fraud division was implementing a balanced caseload for its regional offices and prosecuting agencies that includes high-impact referrals. Our review of the fraud division's case management database shows that between September 2001 and December 2003 half of the cases it submitted to district attorneys were considered high impact. Specifically, of the 233 referrals the fraud division submitted to district attorneys, 116 were high impact and 117 were not. Also, investigators spent almost two-thirds of all the time charged during this period on high-impact cases. However, because the fraud division did not establish baselines for these types of fraud and set targets for the number of high-impact cases it would submit for prosecution, it cannot know whether these statistics align with the insurance commissioner's initiatives or not.

We reviewed the 3,000 high-impact referrals entered in the fraud division's case management database from September 2001 through December 2003 and determined how much time fraud investigators spent on these referrals and how many of the referrals were ultimately submitted to district attorneys or closed without being submitted. As shown in Figure 9, of the

FIGURE 9

Outcome of High-Impact Referrals the Fraud Division Received From September 2001 Through December 2003


Open investigations
384 (13%)
Submitted to district attorneys for prosecution
116 (4%)
Not submitted for prosecution and closed 2,500 (83%)

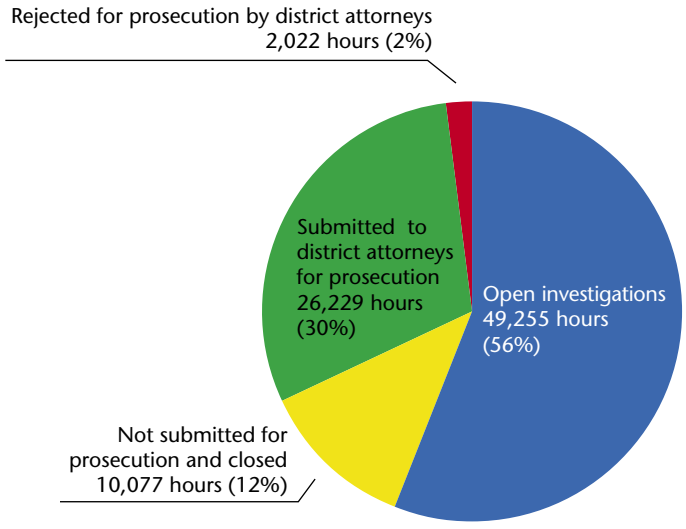
Source: Fraud division's case management database.

high-impact referrals entered in the database, 2,500 (83 percent) were closed without being submitted to district attorneys for prosecution as opposed to 116 that were submitted. Of the referrals submitted for prosecution, district attorneys rejected 10 for prosecution, leaving only 106 (4 percent) that were submitted to district attorneys and filed for prosecution.

When we looked at the amount of time investigators spent on high-impact cases, we found that the majority of time was spent on referrals that had not been submitted to district attorneys as of December 2003. Specifically, as shown in Figure 10, 56 percent (49,255 hours) of investigators' time was spent on investigations that were still open, and 12 percent (10,077 hours) was spent on referrals that were closed and not submitted for prosecution. In contrast, investigators spent 32 percent of their time investigating high-impact referrals that were submitted to district attorneys, of which 30 percent (26,229 hours) was spent on investigations that were accepted or still under consideration by district attorneys for prosecution, and 2 percent (2,022 hours) was spent on referrals that the district attorneys ultimately rejected for prosecution.

FIGURE 10

Outcome of Hours Fraud Division Investigators Spent on High-Impact Referrals From September 2001 Through December 2003



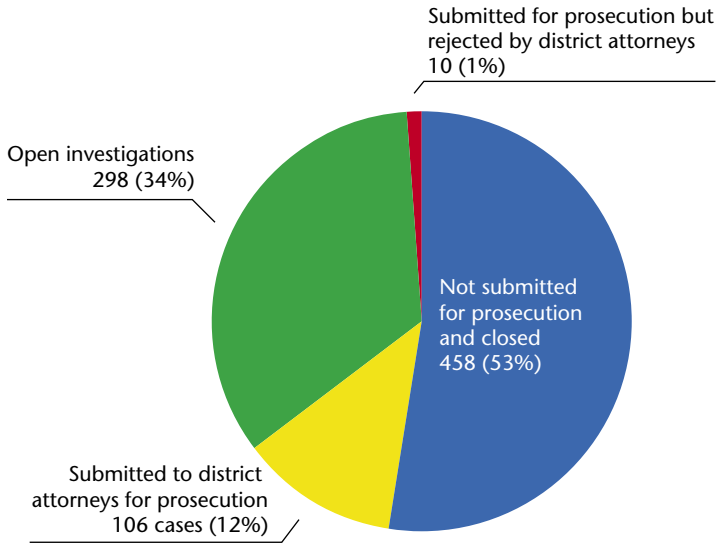
Source: Fraud division's case management database.

The fraud division closes the majority of the high-impact referrals it receives without investigating them. When fraud division supervisors review referrals, they review the information on the referral form and other information to determine whether to assign the referral to an investigator and give it a priority level. When fraud division supervisors decide to close a referral, they list a reason for not investigating it. We found that investigators charged hours on only 872 of the 3,000 high-impact referrals the fraud division received from September 2001 through December 2003, leaving 2,128 with no hours charged. Of those, 86 are still open and 2,042 were closed without assigning them to an investigator.

Furthermore, when we exclude high-impact referrals that the fraud division did not assign to investigators, as shown in Figure 11, more than half the 872 high-impact referrals assigned to investigators were closed without being submitted to district attorneys for prosecution. As a result, it is reasonable to assume that half the open investigations, or about 149 cases during the period we reviewed, will most likely not be submitted to district attorneys for prosecution.

FIGURE 11

Outcome of High-Impact Referrals for Which Fraud Division Investigators Charged Time From September 2001 Through December 2003


Submitted for prosecution but rejected by district attorneys 10 (1%)
Open investigations 298 (34%)
Not submitted for prosecution and closed 458 (53%)
Submitted to district attorneys for prosecution 106 cases (12%)

Source: Fraud division's case management database.

The reason listed for closing the majority of the high-impact referrals—at least 1,427 (70 percent) of the 2,042 referrals—was insufficient evidence. According to the fraud division, insurers are required to send only the basic information provided on the division's referral form, an example of which is shown in Appendix B. If the supervisor reviewing the referral determines that the referral has merit, the case will be assigned to an investigator, and the fraud division will request to review the insurer's claim file.

The Fraud Division Has Not Defined Benchmarks or Targets for Each Appropriate Activity and Used Them to Measure Performance

A benchmark or target provides a means for making a quantified comparison between the actual result and the result intended or benchmarked. However, the fraud division has set no meaningful benchmarks that it periodically uses to measure its actions against.

Benchmarks or anticipated targets are indicators that could help in an assessment of the actual impact of the fraud division's actions. A benchmark or target provides a means for making a quantified comparison between the actual result and the result intended or benchmarked. The comparisons can provide important information for management to use in determining whether the fraud division's antifraud program is operating as intended and whether resources are being allocated appropriately. However, the fraud division has set no meaningful benchmarks against which it could periodically measure its actions.

The fraud division has not come up with a way to measure the return on investment regarding its investigative activities and its success in fighting fraud. It currently reports to the fraud commission on the number of fraud referral cases it opened, the number prosecuted by district attorneys, the number of arrests and convictions arising from these cases, and the related dollar amounts of the fraud charged, as well as a description of its outreach efforts. However, the fraud division has yet to establish a target for how many investigations it plans to submit to the county district attorneys per year and how many of those investigations it expects district attorneys to successfully prosecute each year so that it can measure the success or failure of its investigative efforts funded by the fraud assessment. It also has yet to measure the extent to which various types of fraud occur in the workers' compensation system and establish baselines it can use to target both its own and the district attorneys' activities.

For example, if the fraud division were to project that medical provider fraud contributes $50 million annually to the cost of the workers' compensation system, it could then set targets for the

annual number of provider fraud referrals it would investigate, the annual number of those referrals it would submit to district attorneys to prosecute, and the annual amount of chargeable fraud that would result from successful prosecutions. These targeted amounts could then be compared to the fraud division's and the district attorneys' actual results for the year to measure their success in meeting the targeted benchmarks. Further, in the following year, if the fraud division again projected the amount of provider fraud and found that the cost of this type of fraud added $40 million to the system annually, it would provide a strong indicator that the fraud assessment funds used in fighting provider fraud were paying off.

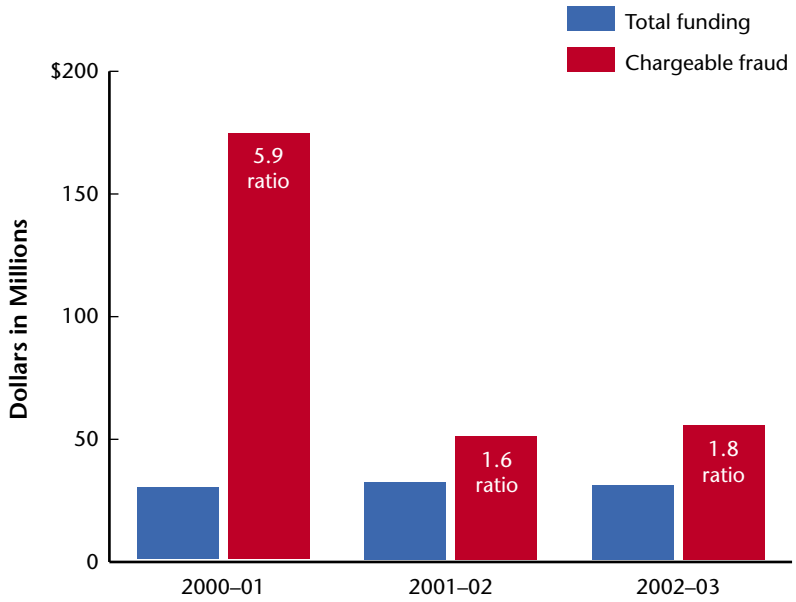
As another example, the division could measure its return on investment by setting a targeted return on the fraud assessment funds invested in the program compared to the amount of chargeable fraud taken out of the system based on successfully prosecuted cases. As shown in Figure 12 on the following page, we compared the aggregate workers' compensation fraud assessment for the last three fiscal years to the amount of chargeable fraud that district attorneys reported to the fraud division. We found that the actual ratios of assessment funds spent compared with the dollar value of fraud charged for fiscal years 2001–02 and 2002–03 are 1.6 and 1.8, respectively. Therefore, the fraud division could set the targeted ratio for fiscal year 2004–05 at 3.0, which, if reached, would result in prosecutions of $3 of chargeable fraud for every fraud assessment dollar spent on the program.

Although the amount of chargeable fraud shown in Figure 12 might be skewed in any given year because the fraudulent activities could have occurred in prior years and investigations and prosecutions of those activities might span more than the current year being reported, it is one example of how the fraud division could develop some measurements of the return on investment for the workers' compensation antifraud program that the fraud commission could use in determining aggregate funding levels and the fraud division could use in measuring its own effectiveness. Other measurements could be developed using the annual fraud assessment funds invested compared with the annual restitution ordered by the court and the amounts actually collected.

The fraud division measures its and the district attorneys' effectiveness by focusing on statistics involving the number of arrests, number of convictions, amount of chargeable fraud,

FIGURE 12

Total Funding for the Workers' Compensation Antifraud Program and Chargeable Fraud Detected for Fiscal Years 2000–01 Through 2002–03



Source: Program reports submitted to the fraud division by county district attorneys.

In April 2002, the division chief sent out memorandums to each regional office instructing them to spend more fraud assessment funds and concentrate on wrapping up cases and forwarding them to district attorneys by the end of the year to ward off criticism that the division does not adequately investigate workers' compensation fraud cases.

number of cases opened, number of cases prosecuted, and other activity levels in developing performance metrics for its own and the district attorneys' activities. However, the fraud division and district attorneys might be able to influence some of this kind of data. For example, in April 2002 the division chief sent out memorandums to each regional office instructing them to spend more fraud assessment funds and concentrate on wrapping up cases and forwarding them to district attorneys by the end of the year to ward off criticism that the division does not adequately investigate workers' compensation fraud cases.

Also, as discussed in Chapter 1, the process of awarding grants does not include a method to decide the most effective distribution of grant funds in part by matching district attorneys' performance against the objectives included in their respective applications. The current decisions regarding the size of these grants are based largely on a variety of statistics regarding actions taken by district attorneys that are provided without any context as to whether those numbers represent success in achieving the objectives set forth in the district attorneys' applications.

THE DIVISION DOES NOT ADEQUATELY MONITOR THE USE OF FRAUD ASSESSMENT FUNDS AWARDED TO DISTRICT ATTORNEYS

The Department of Insurance undertakes two efforts to monitor the use of fraud assessment funds. However, neither is adequate to ensure that the county district attorneys comply with the terms they agreed to when they submitted their grant applications. Department of Insurance regulations require that each county submit an annual independent audit certifying that the county district attorney's expenditures complied with the laws, regulations, request for application guidelines, and the county plan. Although the request for application guidelines include audit procedures that must be addressed in these annual audits, all but one of the audits we reviewed failed to adhere to these procedures.

Additionally, the Ethics and Operational Compliance Office (audit unit) within the Department of Insurance reviews county district attorneys' use of workers' compensation fraud assessment funds. Although the audit unit has reported numerous findings and has recommended that county district attorneys return more than $100,000 in questionable expenditures, it has reviewed only 13 of the 37 county district attorneys who received grant funding in the last two years. Therefore, the audit unit, too, is not providing the audit coverage required to adequately ensure that all county district attorneys complied with the terms they agreed to in their applications for the funds.

In the Audit Reports They Submit Annually, District Attorneys Do Not Provide Adequate Assurance That They Used Fraud Assessment Funds Properly

Department of Insurance regulations require that each county district attorney submit an annual independent audit to the fraud division certifying that the district attorney's expenditures complied with state laws, Department of Insurance regulations, request for application guidelines, and the county plan. The guidelines in the request for application require the review of the internal control system as it applies to the district attorney's workers' compensation antifraud program and lists 14 audit procedures that must be followed during the annual audit. Among the procedures called for are those shown in the text box on the following page. However, all but one of the audits we reviewed failed to adhere to these requirements. In fact, 26 of 27 audits we reviewed did not include the required certification, nor did

Some Audit Requirements Specified in the Request for Application Guidelines

- Determine that expenses charged to the antifraud program are limited to personnel funded by the grant.
- Determine that direct charges to the program are not included in indirect costs also charged to the program.
- Determine that equipment purchased with funds from the fraud assessment grant is in the custody and use of the personnel funded by the grant.
- Identify costs that are questioned or disallowed for the grant period because of noncompliance.
- Certify in the report that county expenditures were made for the purposes of the program as specified by law, Department of Insurance regulations, the guidelines in the request for application, and the county plan.

they comment on the internal control system as it applied to the workers' compensation antifraud program. Moreover, these reports did not provide an opinion on the district attorneys' compliance with laws, regulations, contracts, and grant provisions. Rather, they performed certain tests to obtain reasonable assurance that the financial statements were free of material misstatement. We do not believe audits such as these meet the criteria stated in the law and the grant application guidelines. Furthermore, one county district attorney in our sample had yet to submit an audit report for fiscal year 2001–02 as of February 2004, 15 months after the deadline.

The requirements for audits in the district attorneys' workers' compensation antifraud program are similar to those for the compliance audits required by the federal government for grant funds it provides to state and local governments. The federal government requires that auditors test transactions and perform other audit procedures necessary to support an opinion on compliance to be included in the audit report. We believe an adequate audit of county expenditures could rely on a sample of transactions and other procedures similar to the federal government's requirements to offer an opinion on the level of compliance for each county.

In contrast, the annual audits of county district attorneys appear to focus mainly on the fairness of the financial statements. Many contain standard language giving negative assurance that nothing came to the auditors' attention that would lead them to conclude that the district attorney was in violation of the law or regulations. This sort of review does not give the fraud division assurance that the expenditures of antifraud program funds were in compliance with the program described by the county district attorney in the application for grant funds. Therefore, the fraud commission and the fraud division cannot rely on these audits to verify whether the county district attorney followed the antifraud program he or she agreed to implement as part of the grant application.

According to the fraud division's workers' compensation bureau chief, the fraud division has not required that the annual audit reports contain the required certification because the county auditors preparing the audit reports usually do include general

language stating that the funds from the fraud assessment are being used appropriately by the county district attorneys, which appears to satisfy the requirement for the fraud division staff. Nevertheless, in the audit reports we reviewed, we found no positive assurance that fraud assessment funds were being used appropriately.

Department of Insurance Audits Provide Limited Assurance That District Attorneys Properly Use Fraud Assessment Funds

Department of Insurance audits of county district attorneys' use of workers' compensation fraud assessment grants give a thorough and documented indication of their compliance with the requirements of the grants. However, the audit unit has only completed a limited number of these audits.

The audit unit voluntarily performs audits of county district attorneys' use of fraud assessment funds. Although the audit unit is not statutorily required to audit grants of workers' compensation fraud assessment funds, it is required to review county district attorneys' compliance with the grants for other antifraud programs, such as the one for auto insurance. During those audits, audit unit staff also look at how the district attorneys charge time and expenses to grants for the workers' compensation antifraud program and whether they violate any of the grant requirements. The audit unit reviews expenditures to determine whether the district attorneys use the grants of fraud assessment funds in accordance with the law, Department of Insurance regulations, and the guidelines in the application submitted for the funds. We reviewed the work papers supporting these audits and believe they give a thorough and documented indication of the county district attorneys' compliance with the requirements of the grants of workers' compensation assessment funds. However, the audit unit has completed only a limited number of these audits.

During the last two years, the audit unit has reviewed 13 of the more than 30 county district attorneys that receive workers' compensation fraud assessment grants, reported 38 findings, and recommended that these district attorneys return $103,400 in grant funds because of questionable expenditures. County district attorneys have returned $55,300, or 53 percent, and the Department of Insurance sent out collection letters for the remaining $48,100 at the end of February 2004.

Although its audits are effective and result in the detection and recovery of questionable expenditures, the audit unit's coverage of district attorneys is limited because it does not have sufficient staff to audit all district attorneys that receive workers' compensation fraud assessment grants on a regular basis. In fact, the audit unit has not recently reviewed 22 of the 34 county district attorneys that received fraud assessment funds in fiscal year 2002–03, and reviews of the five county

district attorneys receiving the largest amounts of grant funds have not been conducted since 1998. Further, although the chief of the audit unit told us he does not plan to stop auditing any of these programs, he said he places county district attorneys who receive only workers' compensation grant funds at the bottom of the audit plan, as he receives no funding to conduct these audits. However, if the fraud division required the county district attorneys to submit audit reports from their independent auditors that met the requirements in the Department of Insurance regulations and fraud grant application guidelines and included an opinion on compliance, the audits performed by the audit unit would not be necessary.

If the fraud division required the county district attorneys to submit audit reports from their independent auditors that met the requirements in the Department of Insurance regulations and fraud grant application guidelines and included an opinion on compliance, the audits performed by the audit unit would not be necessary.

RECOMMENDATIONS

To ensure that it fulfills all aspects of its role in the workers' compensation antifraud program, the fraud division should take the following steps:

- Recognize its responsibilities beyond investigating fraud, including using documented past performance and future projections to advise the fraud commission and the insurance commissioner on the optimum annual amount of aggregate assessment needed by the program to fight workers' compensation fraud and the most effective distribution of the funds assessed to investigate and prosecute workers' compensation fraud, and reporting on the economic value of insurance fraud and making recommendations to reduce it.

- Modify its business plan to meet noninvestigative responsibilities, including establishing appropriate goals and objectives, activities, and priorities.

- Establish benchmarks to measure its and the district attorneys' performance in meeting goals and objectives and to determine whether the program is operating as intended and resources are appropriately allocated.

- To meet its noninvestigative responsibilities, the fraud division should realign its resources to enable it to conduct the research necessary to fulfill its statutory role as an advisor regarding the level of funding and the direction of fraud reduction efforts. The research should include measuring the nature and extent of fraud in the workers' compensation

system and the effect of antifraud efforts and monitoring the performance of county district attorneys who receive grants of fraud assessment funds.

- Reevaluate the process it has established for insurers and other state entities involved in employment-related activities to report suspected fraud. The fraud division should identify the type of referrals and level of evidence it requires to reduce the number of hours it spends on referrals that it ultimately does not pass on to county district attorneys for prosecution.

To justify the use of fraud assessment funds, the fraud commission and the insurance commissioner should require the fraud division to conduct a return-on-investment analysis for the workers' compensation antifraud program as a whole and to annually report the results to the fraud commission and the insurance commissioner.

To improve the level of assurance contained in the independent audit reports submitted by county district attorneys regarding fraud assessment funds being spent for only program purposes, the fraud division should do the following:

- Clarify its expectations for the independent audits by seeking a change in the Department of Insurance regulations that would require audit reports to provide an opinion on county district attorneys' level of compliance with key provisions of the applicable laws, regulations, and terms of the fraud assessment grants.

- Ensure that county district attorneys comply with the independent audit requirements and promptly submit their audit reports. ■

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CHAPTER 3

Efforts to Detect and Prevent Workers' Compensation Fraud Are Inadequate and Lack Cooperation Between Agencies

CHAPTER SUMMARY

Improvement is needed in efforts to detect and report suspected fraud to the Department of Insurance's Fraud Division (fraud division). Although the law requires insurers to maintain units to detect fraud and report it to the fraud division, insurers vary greatly in the number of suspected fraud cases they report. The insurance commissioner stated that the lack of a uniform methodology and standards are one reason that insurers are not following through in their responsibility to fight fraud. However, the State Compensation Insurance Fund (State Fund) states that concerns about civil litigation affect the manner in which it refers suspected fraud to the fraud division. The Department of Insurance's recent efforts to redefine regulations to clarify reporting standards and the actions it plans to take to increase referrals do not appear to adequately address the State Fund's concerns about reporting suspected fraud to the fraud division. Moreover, insurers apparently are not providing the fraud division with many referrals concerning the types of fraud that the insurance commissioner considers high impact and therefore high priority for investigation.

The fraud division does not adequately review insurers' special investigative units and their efforts to detect and report suspected fraud to ensure that they comply with the law, nor does it inform insurers of the type and quality of referrals it needs to efficiently meet its responsibilities. It also fails to review a significant number of the insurers it is authorized to audit and does not have adequate standards and procedures in place to conduct its audits. In addition, the fraud division does not adequately track findings from its reviews of insurers' special investigative units and has not established effective practices to encourage adherence with the law to detect and report suspected workers' compensation fraud.

Increased cooperation and information sharing is needed among agencies that accumulate data that could help reduce workers' compensation fraud. A division within the Department of Industrial

Relations (Industrial Relations) performs reviews to determine whether employers comply with certain labor law requirements, including whether they have secured workers' compensation insurance for their injured employees. Even though these reviews could be useful in detecting insurance fraud and unlawfully uninsured employers, the division in Industrial Relations does not share the results of its reviews with the fraud division.

Industrial Relations also has not implemented three legislatively mandated programs designed to detect unlawfully uninsured employers, provide a protocol for reporting suspected fraud, and warn program participants against committing workers' compensation fraud. The result of implementing these provisions would be useful to the fraud division's antifraud efforts.

Finally, the formula Industrial Relations uses to compute and collect fraud assessment surcharges from the State's employers is flawed. Industrial Relations is responsible for collecting and depositing the surcharges in the fraud account in the Insurance Fund that the fraud division uses to pay for its antifraud activities and that funds grants awarded to district attorneys to fight workers' compensation fraud. However, the formula Industrial Relations uses overcharges the State's insured employers. Moreover, Industrial Relations has not implemented procedures that would ensure that insurers remit the correct amount of the fraud assessment surcharge.

IMPROVEMENT IS NEEDED IN REPORTING POTENTIAL FRAUD TO THE FRAUD DIVISION

The fraud division receives referrals of suspected fraud primarily from insurers, but it has not adequately worked with insurers to define the level of evidence it needs to further investigate the referrals. The actions that the fraud division and the Department of Insurance plan to take, including redefining the regulations governing insurers' review of claims and reporting of suspected fraud—functions usually performed by insurers' special investigative units—do not address the current barriers to achieving better reporting of suspected fraud. Although the numbers of suspected fraud referrals the special investigative units report vary greatly, the audits the fraud division has performed do not represent a significant portion of the workers' compensation market, fail to ensure that the special investigative units comply with the law and are poorly finalized, tracked, and enforced.

Insurer Compliance With Requirements to Detect and Report Suspected Workers' Compensation Fraud Varies

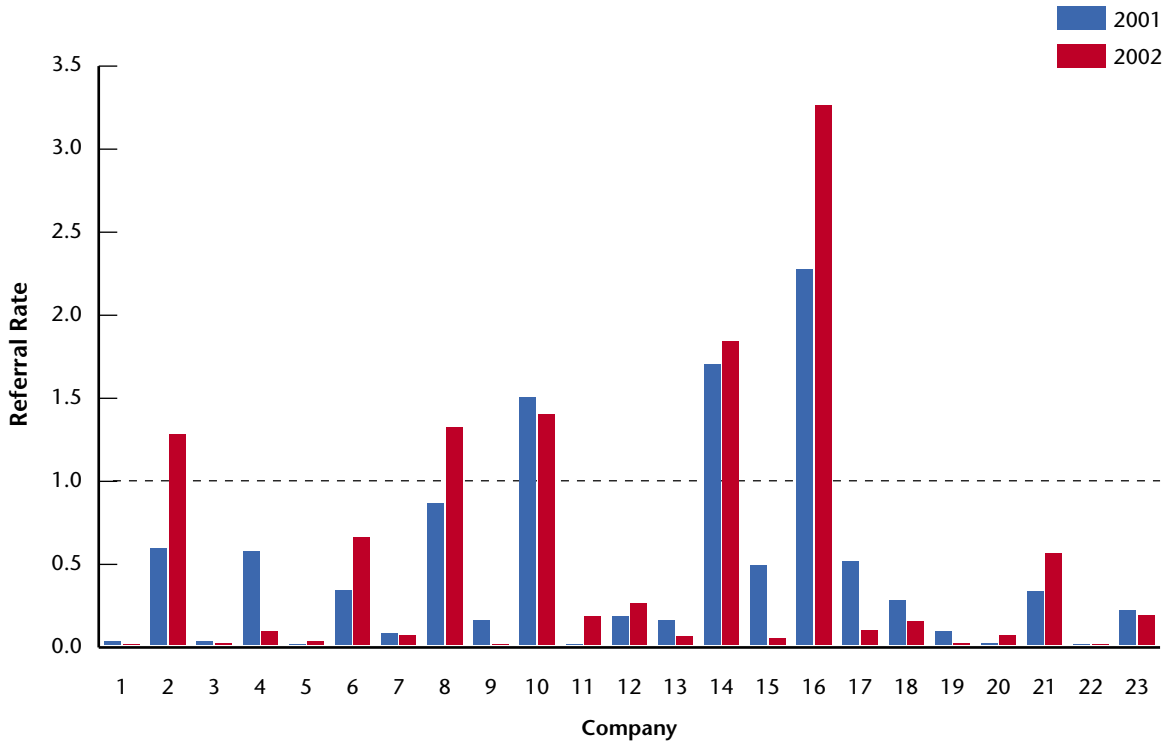
Despite a requirement that insurers investigate suspected fraud and refer to the fraud division claims that show reasonable evidence of fraud, insurers vary significantly in the number of fraud referrals they submit.

Despite a requirement that insurers investigate suspected fraud and refer to the fraud division claims that show reasonable evidence of fraud, insurers vary significantly in the number of fraud referrals they submit. Insurance Code, Section 1875.20, states that every insurer must maintain a unit to investigate possible fraudulent claims, and Section 1872.4(a) requires an insurer to submit a referral to the fraud division within 60 days after determining that a claim appears to be fraudulent.

As shown in Figure 13, among insurers earning workers' compensation premiums exceeding $40 million per year, some appear to be underreporting suspected workers' compensation fraud while others appear to be regularly referring suspected fraudulent claims. For our analysis, we measured the referral rate by obtaining data on the number of referrals from the fraud division and calculating the referrals per $1 million in earned premiums for all insurers earning more than $40 million annually in workers'

FIGURE 13

Referral Rate of Insurers Earning More Than $40 Million in Annual Premiums During 2001 and 2002



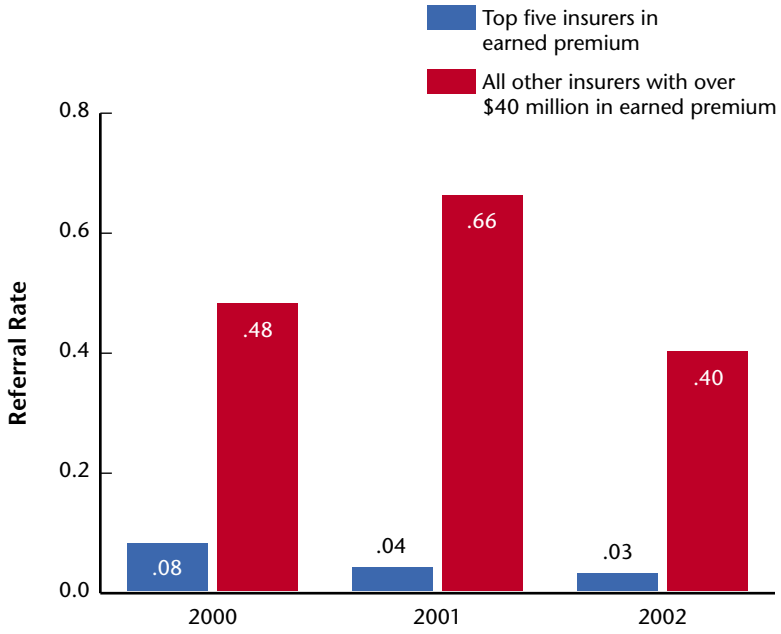
Sources: Department of Insurance Web site and the fraud division's case management database.

compensation premiums in California during both 2001 and 2002. As shown, five of the 23 companies in this group referred more than one claim per $1 million in earned premiums in at least one of the two years. It appears that some of the remaining 18 insurers may be failing to fulfill their responsibilities to refer suspected fraud, including a few insurers that did not submit a single referral in a given year.

Using the same method of calculating referral rates, we also found that the five insurers reporting the highest earned premiums for 2000 through 2002 referred suspected claims at a much lower rate than those reporting lower levels of earned premiums. As shown in Figure 14, the referral rate for the top five insurers in 2002 was 0.03, or less than one suspected fraudulent claim per $20 million in earned premiums. All other workers' compensation insurers earning more than $40 million in premiums in 2002 had a referral rate of 0.40, which translates to eight claims per $20 million in earned premiums. The referral rates were significantly lower for the top five companies in 2000 and 2001 as well.

FIGURE 14

Referral Rates for Workers' Compensation Insurers by Earned Premium for 2000 Through 2002



Sources: Department of Insurance Web site and the fraud division's case management database.

Barriers Exist That Prevent Insurers From Consistently Referring Suspected Fraud

The insurance commissioner and the fraud division cite several factors they believe are likely getting in the way of insurers reporting suspected fraud as required. The insurance commissioner stated that the lack of a uniform methodology and standards for assessing and reporting suspected fraud is one reason that some insurers may be derelict in their responsibility to fight fraud. When we asked the chief of the fraud division about the problems that insurers have with reporting suspected fraud cases, he stated that past regulations poorly defined when insurers should refer suspected fraud to the fraud division. The insurance commissioner also stated that the quality and quantity of referrals from insurers are key problems and are the primary reason for adopting revised emergency regulations.

According to the assistant chief deputy commissioner, the Department of Insurance is increasing its efforts to monitor insurers' investigative units, including developing a new audit methodology and working with the insurance industry to permanently amend the regulations to better define when suspected fraud is reportable. She stated that temporary emergency regulations are already in effect until May 2004 for that purpose. The assistant chief deputy commissioner also stated that the Department of Insurance plans to refine the operations of the fraud division's special investigative audit unit to increase its audit coverage and then seek additional staff.

State Fund believes there is civil liability associated with referring suspected fraud cases. According to State Fund's special investigative unit manager, the courts have interpreted a reported suspected fraudulent claim to be equivalent to an accusation, and therefore subject to a malicious prosecution claim.

The law states that to refer a case of suspected fraud, an insurer must have a "reasonable belief" the fraud actually occurred. However, the State Fund believes that civil liability is associated with referring suspected fraud cases. According to the State Fund's special investigative unit manager, the courts have interpreted a reported suspected fraudulent claim to be equivalent to an accusation and therefore subject to a malicious prosecution claim. However, she believes she protects her organization by having in place the facts needed to defend the State Fund against any potential lawsuit. The special investigative unit manager stated that she focuses on the definition of fraud—in particular, the elements of the crime, which she describes as a lie, knowledge, intent, and materiality. Once her investigators are able to substantiate these four things, she believes the State Fund can then assert, in good faith, that its investigators have a reasonable belief of suspected fraud that requires the State Fund to report the case to the fraud division and district attorneys. Without these four elements, the special

investigative unit manager believes she would have a difficult time proving in court that her special investigators acted with reasonable belief.

Given the fraud division's limited resources for investigating referrals and the large number of referrals it closes for lack of evidence, it seems reasonable that the fraud division would benefit from working with insurers to help them understand the level of evidence needed to successfully investigate a referral and submit it for prosecution. According to the special investigative unit manager for the State Fund, rather than sending a suspected fraud referral to the fraud division using only the required referral form, the State Fund sends documented referrals that are prepared according to the documented referral protocol of the California District Attorneys Association and the Department of Insurance. The referrals include substantiating evidence along with the referral form. The special investigative unit manager indicated that her unit submits the evidence along with its referrals because documented referrals are more likely to be investigated by the district attorneys or the fraud division. She noted that in many instances, if a special investigative unit makes a referral using only the required referral form, the referrals are not investigated because there is not enough information to get a clear picture of the case and to generate interest in pursing the investigation. She also stated that submitting unsubstantiated allegations is a waste of time for the insurers' special investigative units, the district attorneys, and the fraud division.

According to our review of its database of fraud referrals, the fraud division received almost two-thirds of its referrals from insurers, 89 percent of these referrals were for claimant fraud, which do not appear to be the high-impact referrals the insurance commissioner has identified as a priority for the workers' compensation antifraud program.

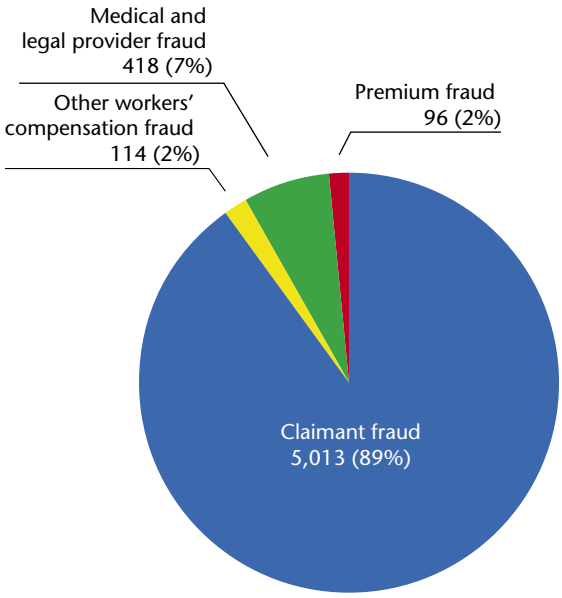
As a result of these two differing opinions of the problems with the current suspected fraud referral process, and given that the fraud division is not adequately monitoring insurers, we believe the actions the Department of Insurance and fraud division have taken or plan to take, such as adopting emergency regulations, will not adequately address the State Fund's concerns about reporting suspected fraud, including the level of evidence provided by insurers with referrals that the fraud division expects to further investigate. For example, the emergency regulations define suspected fraud that requires reporting as a case in which "facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud." However, the Insurance Code already requires insurers to report any case involving what they reasonably believe is fraudulent activity.

Likewise, insurers apparently are not reporting the types of suspected fraud the insurance commissioner has designated as high-impact and the fraud division has made a priority to investigate. According to our review of its database of fraud

referrals, although the fraud division received almost two-thirds of its referrals from insurers, 89 percent of those referrals were for claimant fraud, which does not appear to be among the high-impact types of fraud the insurance commissioner has identified as a priority for the workers' compensation antifraud program. Figure 15 shows the types of suspected fraud referrals insurers reported from September 2001 through December 2003. During that period, the fraud division spent more than 13,000 hours investigating cases referred by insurers that it ultimately closed without referring to district attorneys for prosecution.

FIGURE 15

Types of Suspected Fraud Referrals Insurers Reported From September 2001 Through December 2003



Source: Fraud division's case management database.

The Fraud Division Lacks an Adequate Strategy for Its Special Investigative Audit Unit

The fraud division has made some internally weak efforts to review insurers' compliance with the legal requirement to detect and refer suspected fraud. The fraud division's special investigative audit unit performs reviews of insurers to determine whether they comply with fraud reporting requirements. However, a lack of strategic planning has left the special investigative audit

unit without a program that effectively targets insurers to achieve maximum compliance with reporting requirements, and it has not developed a standardized auditing approach that would ensure that its reviews are sufficient to determine insurers' compliance with the law. Further, the special investigative audit unit does not promptly prepare reports and follow up on audit findings. Finally, the Department of Insurance has not established effective penalties to promote insurers' compliance.

Audit Efforts Have Not Provided Adequate Coverage of Insurers

The special investigative audit unit has not achieved the most effective audit coverage of the community of workers' compensation insurers. For example, the workers' compensation insurers that the special investigative audit unit reviewed during the past two years do not represent a significant portion of the market. As was shown in Figure 14 on page 86, the rate of referrals of suspected fraud per million dollars of earned premiums for the largest insurers is lower than for insurers with less market share. However, the fraud division focused 59 percent of its audits on insurers that represent less than 0.5 percent of the market.

The special investigative audit unit excluded 43 percent of the insurers selling workers' compensation in the State from review because they do not have offices in California.

In addition, the special investigative audit unit chose not to review 43 percent of the insurers selling workers' compensation in the State because they do not have offices in California. According to the manager of the special investigative audit unit, from the remaining insurers that maintained offices in California, the special investigative audit unit selected insurers for review based on information contained in their annual reports. According to the chief investigator who oversees the special investigative audit unit, the fraud division did not feel it could develop any type of schedule for regular insurer reviews until it had reviewed all or most insurers. He stated that one reason for attempting to review all or most insurers is that insurers had complained about the special investigative audit unit's past practices of auditing only certain insurers while other insurers were not reviewed. He speculated that once the special investigative audit unit had reviewed the majority of insurers, the results of those reviews would indicate the need for a regular review schedule.

Furthermore, the special investigative audit unit reviews an average of only 14.5 (8 percent) of the 175 insurers in the fraud division's workers' compensation database each year. This number is not sufficient to determine whether the community of workers' compensation insurers is adequately complying with fraud-reporting requirements. According to the insurance

commissioner, the special investigative audit unit has not performed more audits of workers' compensation insurers during the past two years because of inadequate staffing levels and travel restrictions. The insurance commissioner stated that although the Department of Insurance is supported exclusively by special fund revenues, the State's budget policy has not permitted growth but instead has mandated spending authority and personnel year reductions. In fact, he stated that departmentwide, 30 positions and $1.8 million in spending authority were eliminated in fiscal year 2001–02; in fiscal year 2002–03 the department lost an additional 31 positions and $1.2 million. Moreover, the insurance commissioner told us that proposals for any program enhancements, regardless of funding source, were strongly discouraged by the Department of Finance. Finally, the insurance commissioner stated that because the special investigative audit unit is also responsible for auditing insurers selling other lines of insurance it cannot focus its resources exclusively on workers' compensation audits.

Nevertheless, time reports for 2003 provided by the manager of the special investigative audit unit show that the four staff members comprising the unit spent from 23 percent to 45 percent of their time working on projects other than special investigative unit reviews. Our review of time-reporting documents and inquiries indicates that staff also spend time on activities that, according to the manager of the special investigative audit unit, included aiding insurers in implementing the electronic suspected fraud referral program, answering technical calls from electronic referral users, and occasionally providing backup for reception and database input.

Without standards for audit objectives, audit procedures, and supervision of the audits, the fraud division cannot be certain that the special investigative audit unit is helping insurers provide referrals of the quality that the fraud division needs to effectively and efficiently investigate workers' compensation fraud.

The Special Investigative Audit Unit Lacks Standards in Its Approach to Auditing Insurers

The special investigative audit unit has not established procedures that include standards for auditing insurers' special investigative units. Without such standards for audit objectives and procedures, methods for sampling claims transactions, audit evidence, and supervision of the audits, the fraud division cannot be certain that the special investigative audit unit is helping insurers provide referrals of the quality that the fraud division needs to effectively and efficiently investigate workers' compensation fraud.

According to the manager of the special investigative audit unit, determining what audit procedures are being used would demand interviewing each reviewer to determine his or her method for conducting a review. Not surprisingly, the reviews

we examined reflected disparate approaches. Moreover, seven of the 10 audits we reviewed relied heavily on interviews and self-reporting by insurers, were lacking in documentary evidence, and did not adequately test claims for insurers' compliance with required procedures for handling potentially fraudulent claims.

For example, according to one reviewer in the special investigative audit unit, one audit procedure that reviewers should perform is determining whether insurers accurately report suspected fraud cases to the fraud division. However, we noted that the reviewer accepted a verbal assurance from the insurer that it had sent the number of referrals that the fraud division had in its database, rather than verifying that all suspected cases of fraud resulted in reported referrals. According to the manager of the special investigative audit unit, it did not have a policy to select actual claims for testing until the summer of 2003, and it is still not a written policy. Moreover, of the 10 reviews we examined, we found only four in which the reviewers sampled claims to search for unreported indicators of fraud, and in two of those cases, the reviewer allowed the insurer to select the claims for review. Finally, the reviewers did not accurately document determinations as to why they found an insurer to be in compliance with fraud-reporting requirements.

Of the 10 reviews we examined, we found only four in which the reviewers sampled claims and in two of those cases the reviewer allowed the insurer to select the claims for review.

According to the chief investigator who oversees the special investigative audit unit, the fraud division is preparing a manual of procedures for conducting reviews, and it has already implemented a policy to use a standard random sampling methodology with a minimum sample of 30 claims per audit to review for unreported suspected fraudulent claims. The manager stated that the procedures manual will cover how to select insurers for review and procedures for preliminary auditing activities, fieldwork, reporting, and supervisor review. According to the manager of the special investigative audit unit, the manual will represent the procedures the special investigative audit unit currently has in place. However, we found in our review that the procedures actually practiced by the staff of the special investigative audit unit do not reflect the procedures the manager described as currently being in place.

The Special Investigative Audit Unit Does Not Promptly Finalize Its Reports or Track and Enforce Audit Findings

For five of the seven audits of insurers with findings that we reviewed, the special investigative audit unit had not sent letters to the insurers outlining the findings, even though between one

and three months had passed since the review was completed. The letters, which discussed reviews performed from October through November 2003, were waiting for manager review. According to the manager of the special investigative audit unit, she was working on other fraud division priorities, such as new emergency regulations pertaining to the requirements to report fraud and arranging and attending meetings with the insurance industry.

The special investigative audit unit also does not adequately track its audit findings to follow up on corrective action by insurers. According to the chief investigator who oversees the special investigative audit unit, tracking these findings is left up to the individual analysts who perform the audits. The chief investigator stated that the special investigative audit unit would like to enhance the internal tracking of findings and other comprehensive information regarding insurers through the creation of an internal database, but that this is not a top priority.

Although the law states that any insurer failing to comply with fraud-reporting provisions will be subject to a maximum fine of $55,000 and/or suspension of the insurer's certificate of authority to conduct business in the State, the insurance commissioner feels that these two tools are relatively ineffective because they represent two extremes of regulatory enforcement.

Moreover, the fraud division has not established effective penalties to promote compliance with the requirement that insurers maintain a special investigative unit. Although the law states that any insurer failing to comply with fraud-reporting provisions will be subject to a maximum fine of $55,000 and/or suspension of the insurer's certificate of authority to conduct business in the State, the insurance commissioner feels that these two tools are relatively ineffective because they represent two extremes of regulatory enforcement. He stated that although suspension of a company's authority to sell insurance may be an appropriate penalty for the most egregious violations, special investigative unit violations tend to be technical in nature and do not rise to this level. At the other extreme, the insurance commissioner believes that the $55,000 fine is easily paid by insurers and does not constitute an effective deterrent for noncompliance. The insurance commissioner stated that financial penalties have been levied in the past, but license suspension has not been used for the reason just described.

Based on the special investigative audit unit's own reviews, insurers are not complying with the requirements in law related to special investigative units. The reviews we examined show an average of 1.7 findings per insurer. Out of our sample of 10, one insurer did not meet the statutory standards of maintaining a fraud-reporting function, and four had failed to make any referrals of suspected fraud to the fraud division as called for by the law.

IMROVEMENT IS NEEDED IN SHARING INFORMATION BEWEEN STATE DEPARTMENTS TO IDENTIFY POTENTIAL WORKERS' COMPENSATION FRAUD

The Department of Industrial Relations' Division of Labor Standards Enforcement (DLSE) does not share the results of its field reviews of employers with the fraud division. An August 2001 report on the workers' compensation antifraud program by the Commission on Health and Safety and Workers' Compensation stated that greater interagency coordination among those entities charged with combating workers' compensation fraud would increase the likelihood of detection, investigation, and successful prosecution of major fraudulent schemes. Although the DLSE investigates and issues civil penalties and stop work orders for noncompliance with certain labor laws, including laws relating to workers' compensation, it does not routinely refer employers that fail to provide workers' compensation insurance to the fraud division for consideration of possible criminal prosecution of fraud.

Without greater sharing of fraud information, the fraud division is denied information that Industrial Relations possesses on employers that fail to provide workers' compensation insurance for their employees. According to the fraud division chief, he has sought to improve information sharing between the fraud division and divisions within Industrial Relations through possible memorandums of understanding. However, the chief added that because of recent administration changes at Industrial Relations, his contacts have changed and he has not been able to finalize the planned memorandums of understanding.

During 2003 the Division of Labor Standards Enforcement conducted 6,816 field reviews and cited nearly 1,300 employers for failing to carry workers' compensation insurance.

The DLSE conducts field reviews of employers' compliance with various labor laws as well as with the requirement that employers carry workers' compensation insurance. During 2003 the DLSE conducted 6,816 field reviews and cited nearly 1,300 employers for failing to secure workers' compensation insurance. To enforce labor law requirements, the DLSE issues civil penalties and can order employers to cease using employees in their business operations (stop work orders) until the employers can prove that they have obtained workers' compensation insurance.

According to the assistant labor commissioner, the DLSE does not refer employers that fail to provide workers' compensation insurance to the fraud division for possible investigation. She stated that she is unsure of the benefits that would result from such referrals because the DLSE already enforces workers' compensation insurance compliance on all employers it investigates. However,

the assistant labor commissioner also stated that after being cited, some employers close up shop, declare bankruptcy, liquidate their assets, and reopen at another location and continue to operate. The assistant labor commissioner also stated that the DLSE does not track repeat offenders. As a result, the DLSE cannot gauge the effectiveness of civil penalties in deterring unlawfully uninsured employers. Therefore, the DLSE's practice of not tracking repeat offenders and not referring to the fraud division employers it identifies that fail to provide workers' compensation insurance, denies the fraud division a tool it could use for identifying employers that repeatedly fail to carry workers' compensation insurance, thereby indicating a willful intent that warrants investigation.

The Division of Labor Standards Enforcement's practice of not tracking repeat offenders and not referring to the fraud division employers it identifies that fail to provide workers' compensation insurance denies the fraud division a tool it could use for identifying employers that repeatedly fail to carry workers' compensation insurance, thereby indicating a willful intent that warrants investigation.

INDUSTRIAL RELATIONS HAS YET TO IMPLEMENT REQUIRED PROGRAMS DESIGNED TO DETER WORKERS' COMPENSATION FRAUD

Recent legislation mandates that Industrial Relations implement three antifraud programs: (1) a program to detect employers that willfully fail to secure workers' compensation insurance for their employees; (2) a program establishing a protocol for reporting suspected fraud by medical care providers; and (3) a program requiring Industrial Relations to issue annual warnings against committing workers' compensation fraud to employers, claims adjusters and administrators, medical providers, and attorneys who participate in the workers' compensation system, and to notify them of the relevant penalties. The results of the first two programs would be useful to the fraud division and local district attorneys in their efforts to reduce fraud in the workers' compensation system, and the third program would help deter fraud by notifying participants in the workers' compensation system of the risks associated with committing fraudulent activities. However, Industrial Relations has not yet implemented these programs, citing budget constraints and delays in executing an interagency agreement with the Department of Insurance.

One Unrealized Program Would Enable the DLSE to Identify Employers That Illegally Fail to Provide Workers' Compensation Insurance

According to the assistant labor commissioner, Industrial Relations has not yet established or implemented a program for targeting employers in industries with the highest incidence

The Commission on Health and Safety and Workers' Compensation (commission) concluded that a program targeting certain employers would, if implemented on a permanent basis, be effective in identifying and enforcing mandatory insurance laws for employers who unlawfully fail to provide workers' compensation insurance for their workers.

of unlawfully uninsured employers, even though the law required such a program to be operational as of January 1, 2003. Under the program, the DLSE would work jointly with the Employment Development Department and the Workers' Compensation Insurance Rating Bureau (rating bureau) and would use data from the Uninsured Employers' Fund, which reimburses injured workers whose employers fail to provide workers' compensation insurance. The combined databases from these entities would enable the DLSE to identify businesses that report wages but do not report having workers' compensation insurance coverage and to identify employers whose workers' compensation benefits have been paid by the Uninsured Employers' Fund maintained by Industrial Relations.

The program called for in the law is based on a pilot project coordinated by the Commission on Health and Safety and Workers' Compensation. In a study of the pilot project released in 1999, the Commission on Health and Safety and Workers' Compensation concluded that such a program would, if implemented on a permanent basis, be effective in identifying and enforcing mandatory insurance laws for employers that unlawfully fail to provide workers' compensation insurance for their workers. For example, the study found that 60 percent of employers that were uninsured at the beginning of the pilot project obtained insurance after they received notices of noncompliance.

According to the assistant labor commissioner, the DLSE has not established or implemented the program because it does not have the resources to fund it or the ability to redirect resources to the program from its current budget. The assistant labor commissioner also told us that the DLSE's budget change proposal to fund the program was not approved. If the DLSE had established this mandated program, it may have improved its detection and deterrence of uninsured employers and provided useful data to enhance the statewide antifraud effort.

The results of this required program would be useful to the fraud division and local district attorneys in investigating and prosecuting employers that willfully fail to provide workers' compensation insurance. In the meantime, the fraud division is working on a pilot project with the rating bureau to use information from the rating bureau's databases to identify fraud. However, the information the fraud division provided us did not adequately specify the objectives of its pilot project. If parts of the fraud division's pilot project duplicate the program required of Industrial Relations that it has yet to implement, the costs to

the fraud division to operate the pilot project would represent fraud assessment funds that could be redirected to other antifraud priorities once Industrial Relations fulfills its obligation to implement the program.

The Division of Workers' Compensation Has Not Implemented a Protocol for Reporting Potential Workers' Compensation Fraud

According to Division of Workers' Compensation (DWC) staff, as of February 2004, the DWC had yet to implement the fraud-reporting protocols that the law requires to be operational by January 1, 2004. The legislation requires Industrial Relations to develop a reporting system to help detect medical provider fraud in the State. This type of fraud occurs when a medical provider performs one service and bills for another more expensive service or bills for a service that was never rendered, and it carries a criminal penalty. According to the administrative director of the DWC, the DWC has initiated the preliminary research needed to develop the required protocols for reporting medical provider fraud, but it has not established and coordinated a system for reporting this type of fraud that the DWC, fraud division, Medi-Cal Fraud Task Force, and Bureau of Medi-Cal Fraud and Elder Abuse within the Department of Justice can implement, as the law calls for. Without establishing an effective means for these agencies to use in reporting medical provider fraud, the DWC is missing an opportunity to effectively target and reduce one type of fraud that the insurance commissioner recognizes as high impact and high priority.

An Annual Warning to System Participants Against Committing Workers' Compensation Fraud Is Another Process the DWC Has Yet to Initiate

The DWC has not established a process to warn employers, claims adjusters and administrators, medical providers, and attorneys who participate in the workers' compensation system against committing workers' compensation fraud and inform them of the penalties if they do. Recent legislation required such a program to be operational as of January 1, 2003. In its 1997 report on workers' compensation antifraud efforts, a Commission on Health and Safety and Workers' Compensation task force recommended that, in addition to investigative and enforcement activities, notifying participants of the legal risks of fraud is an important element in deterring it.

The Fraud Assessment Commission set aside $200,000 for the Division of Workers' Compensation (DWC) to use to establish a process to warn employers, claims adjusters, medical providers, and attorneys against committing fraud. However, as of February 2004—over a year later—DWC has not applied for the funds.

The law requires that the Fraud Assessment Commission (fraud commission) provide the DWC with the necessary funds to carry out this notification. In fact, the fraud commission's minutes for its January 2003 meeting show that the fraud commission had set aside $200,000 for the DWC to use to fulfill this responsibility and that the DWC would have to apply for the funding in order to receive it. However, as of February 2004—more than a year later—the DWC has not submitted an application. According to the DWC's legal unit staff, it still has not executed an interagency agreement with the Department of Insurance as required to apply for the funding.

INDUSTRIAL RELATIONS COLLECTS EXCESS FRAUD ASSESSMENTS FROM INSURED EMPLOYERS

As described in the Introduction, Industrial Relations collects a surcharge (fraud assessment surcharge) from employers to provide the annual workers' compensation fraud assessment, as determined by the fraud commission, and deposits the funds it collects in a special workers' compensation fraud account in the Insurance Fund. However, our review of Industrial Relations' collection processes reveals it cannot ensure that it is collecting the fraud assessment surcharge equitably from the State's employers.

Although Industrial Relations consistently transfers the amount the fraud commission targets as the workers' compensation fraud assessment to the Insurance Fund, we found that it often collects much more than it intended because the formula it uses to calculate the surcharge rate usually results in overcharges to insured employers. Industrial Relations holds any overcollections in a special deposit fund and uses the balance of this fund to adjust the collection of the subsequent year's workers' compensation fraud assessment. In addition, even though Industrial Relations suspects that some insurers may be retaining excessive fraud assessment surcharges that they collect from employers, it has not implemented procedures to ensure that insurers report and remit any overcollections from insured employers.

The Formula Industrial Relations Uses to Determine the Fraud Assessment Surcharge Results in Overcharges to Insured Employers

To collect the aggregate workers' compensation fraud assessment determined by the fraud commission, Industrial Relations annually devises a surcharge formula based on the Labor Code and Title 8 of

the California Code of Regulations. The DWC then determines the amount due from the State's insured and self-insured employers, based on the employers' respective payroll figures. The DWC also notifies and collects the portion of the fraud assessment due from insured employers, but it delegates the notification and collection of the portion due from self-insured employers to Industrial Relations' Office of Self Insurance Plans, as required by regulation.

Industrial Relations determines the two portions of the fraud assessment surcharge differently. The Office of Self Insurance Plans directly bills and collects a portion of the fraud assessment surcharge from self-insured employers, and the remaining portion is collected from employers through their respective insurers. Figures 16 and 17 on the following pages show the process Industrial Relations uses to collect the fraud assessment surcharge from insured and self-insured employers.

Each year, Industrial Relations estimates and requests an advance payment of the fraud assessment surcharge from insurers that write workers' compensation policies in California, based on the projected policy premiums for the current year. After paying the advance, the insurers collect the surcharge through the premiums they charge employers. Later, when the policy premiums are known and have been collected, the insurers reconcile the amount of the fraud assessment they have actually collected from employers with the amount of the initial advance payment they made to Industrial Relations. Insurers are expected to report any undercollection of the fraud assessment surcharge from insured employers and remit any overcollection to Industrial Relations.

Industrial Relations' formula for calculating the fraud assessment surcharge to be collected from insured employers results in very large variations between the estimated and actual collections.

Industrial Relations' formula for calculating the fraud assessment surcharge to be collected from insured employers results in very large differences between the estimated and actual collections, signifying that the projection Industrial Relations uses to compute it may be inaccurate. Each year, Industrial Relations holds overadvanced amounts from insurers and overcollections from insured employers in its special deposit fund and uses the ending balance to adjust the aggregate workers' compensation fraud assessment authorized by the fraud commission for the following fiscal year. However, the adjustments have been disproportionately high in recent years and have resulted in large reductions. For example, to calculate the fraud assessment surcharge to be collected from insured employers for fiscal year 2003–04—a year in which the workers' compensation fraud

FIGURE 16

Process of Collecting Fraud Assessment Surcharges From Insured Employers

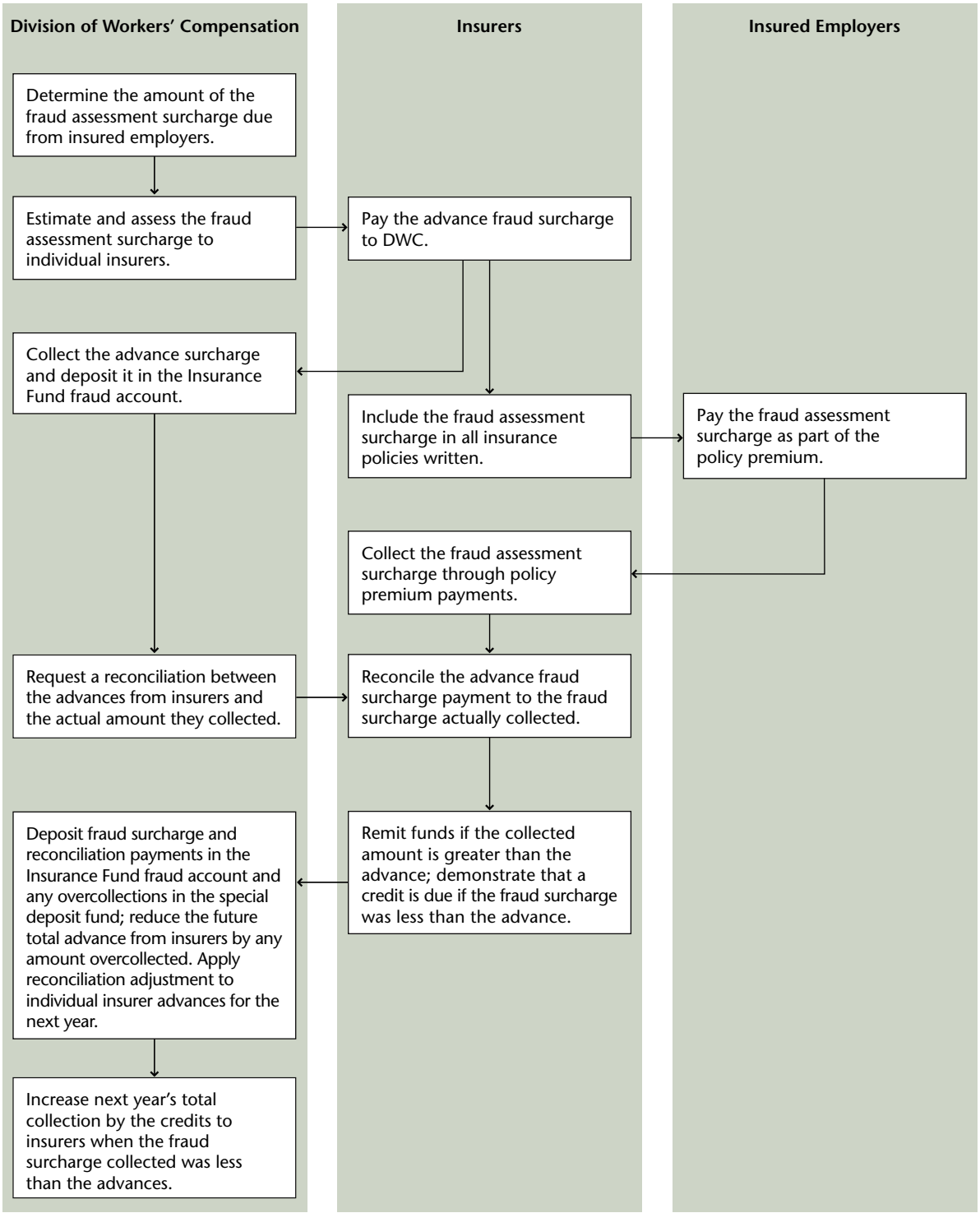
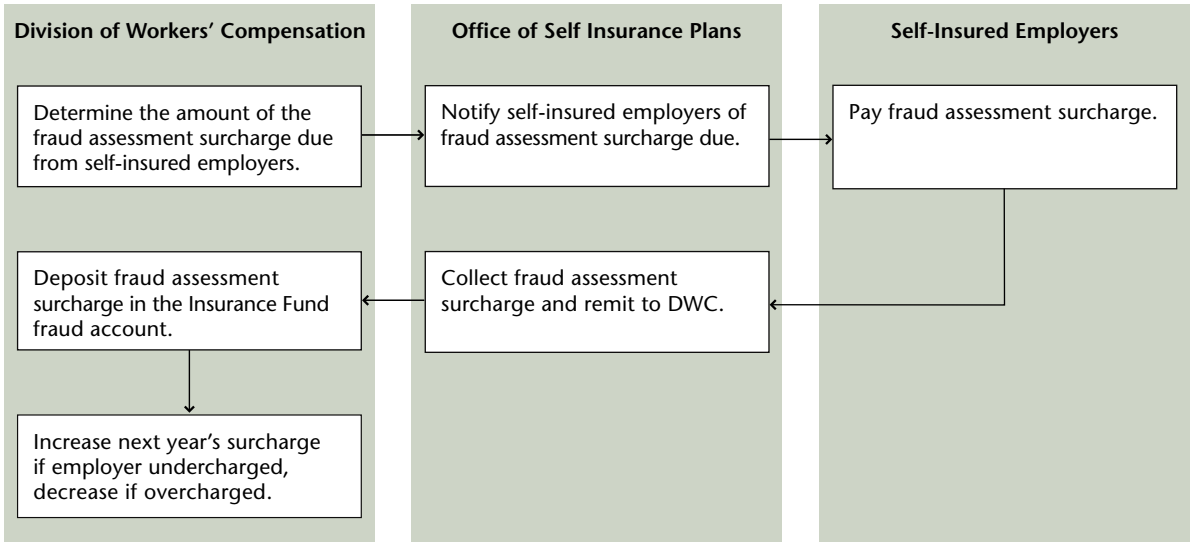

Division of Workers' Compensation
Insurers
Insured Employers
Determine the amount of the fraud assessment surcharge due from insured employers.
Estimate and assess the fraud assessment surcharge to individual insurers.
Pay the advance fraud surcharge to DWC.
Collect the advance surcharge and deposit it in the Insurance Fund fraud account.
Include the fraud assessment surcharge in all insurance policies written.
Pay the fraud assessment surcharge as part of the policy premium.
Collect the fraud assessment surcharge through policy premium payments.
Request a reconciliation between the advances from insurers and the actual amount they collected.
Reconcile the advance fraud surcharge payment to the fraud surcharge actually collected.
Deposit fraud surcharge and reconciliation payments in the Insurance Fund fraud account and any overcollections in the special deposit fund; reduce the future total advance from insurers by any amount overcollected. Apply reconciliation adjustment to individual insurer advances for the next year.
Remit funds if the collected amount is greater than the advance; demonstrate that a credit is due if the fraud surcharge was less than the advance.
Increase next year's total collection by the credits to insurers when the fraud surcharge collected was less than the advances.

FIGURE 17

Process of Collecting Fraud Assessment Surcharges From Self-Insured Employers


Division of Workers' Compensation
Office of Self Insurance Plans
Self-Insured Employers
Determine the amount of the fraud assessment surcharge due from self-insured employers.
Notify self-insured employers of fraud assessment surcharge due.
Pay fraud assessment surcharge.
Deposit fraud assessment surcharge in the Insurance Fund fraud account.
Collect fraud assessment surcharge and remit to DWC.
Increase next year's surcharge if employer undercharged, decrease if overcharged.

assessment to be collected from insured employers was slightly more than $24 million of the $32 million total assessment—Industrial Relations increased the amount due from insured employers by almost $7 million to make up for credits to insurers for past years' advance payments that were too high. At the same time, Industrial Relations reduced the total amount due from insured employers by almost $16 million, which it had accumulated in its special deposit fund as of June 2003 from overcollections from employers in prior years. After adjusting for the credit of excessive advance payments to insurers and overcollections from insured employers, the net fraud assessment surcharge from insured employers for that year was $14.5 million. This is just the most recent example. In fiscal year 2002–03, Industrial Relations reduced the total amount to be collected from insured employers by more than $10 million that it had accumulated in its special deposit fund.

To arrive at the amount that was overcollected from insured employers, Industrial Relations directed insurers to apply an excessive surcharge factor in the workers' compensation policies they wrote, which it based on premium projections from the rating bureau. Industrial Relations' regulations require that it use the rating bureau's projection of total current year premiums to determine the fraud surcharge factor. However, information provided by Industrial Relations suggests that the rating bureau does not always provide accurate estimates of current

year premiums. In recent years, the rating bureau's estimates of current year premiums have been too low, resulting in overcollections. However, in 1994 and 1995, the rating bureau's estimates were as much as 51 percent too high, which under Industrial Relations' formula for calculating fraud assessment surcharges, would result in undercollections.

Industrial Relations Does Not Determine That Insurers Correctly Report All Fraud Assessment Surcharges

Industrial Relations staff noted that in prior years some insurers reported they did not bill their insured employers for fraud surcharges even though the insurers showed premium income in those years.

Even though Industrial Relations suspects that some insurers do not remit all their collected fraud assessment surcharges during the reconciliation process, it has not established a method to audit or otherwise verify the reconciliation submitted by insurers. Typically, when Industrial Relations asks insurers to reconcile their advances to the actual fraud assessment surcharge they collect through premiums, insurers report that the initial advance was either too much, in which case Industrial Relations credits them for the following assessment period, or too little, in which case insurers remit the balance. However, Industrial Relations staff noted that in prior years, some insurers reported they did not bill their insured employers for fraud assessment surcharges even though the insurers showed premium income in those years. In addition, some insurers have reported that the amount paid in advance exactly equaled the amount of fraud assessment surcharges they billed to insured employers, a circumstance that is very unlikely. As a result, Industrial Relations staff suspect some insurers have misreported the amount of fraud assessment surcharge they billed and collected.

Industrial Relations estimates of the amount of the workers' compensation fraud assessment surcharge that insurers have failed to remit ranges from roughly $8 million to $13 million for 1999 through 2001. According to DWC staff, they cannot verify that the reconciliation statements are correct because they have no statutory authority to do so. However, without such verification, Industrial Relations cannot ensure that it receives all the fraud assessment surcharges collected by insurers.

RECOMMENDATIONS

To ensure that it receives the suspected fraud referrals it needs from insurers to efficiently investigate suspected fraud, the fraud division should continue its efforts to remove the barriers that

prevent insurers from providing the desired level of referrals. Additionally, the Department of Insurance should seek the necessary legal and regulatory changes in the fraud-reporting program. These barriers include the following:

- Lack of a uniform methodology and standards for assessing and reporting suspected fraud.
- Regulations that poorly define when insurers should report suspected fraud to the fraud division.
- Perceived exposure to civil actions when criminal prosecutions of referrals are not successful.

Given the number of referrals of suspected fraud cases by insurers that the fraud division has decided not to investigate because of a perceived lack of sufficient evidence to investigate the referrals, the fraud division should work with insurers to reduce the number of referrals that are not likely to result in a successful investigation or prosecution, thereby preserving limited resources. It should also work to ensure that the referrals that insurers do make contain the level of evidence necessary for the fraud division to assess the probability of a successful investigation and prosecution.

Once the fraud division has determined the level of evidence included with the suspected fraud referrals it needs from insurers, it should implement a strategy for its special investigative audit unit to focus the unit's limited resources on determining whether insurers are following the law in providing the referrals that the fraud division needs. That strategy should include the following elements:

- Clear objectives and priorities that will promote adequate audit coverage of workers' compensation insurers.
- Standards for conducting audits of insurers' special investigative units that include audit objectives, audit procedures, methodologies for sampling claims transactions, appropriate audit evidence, and supervision of the audits.
- Issue its audit reports promptly, periodically follow up on audit findings, and develop effective methods of enforcing compliance with the fraud-reporting requirements.

To help the fraud division investigate employers that fail to secure workers' compensation insurance for their employees, the Industrial Relations' DLSE should track employers that do not provide workers' compensation insurance or benefits for their employees and report to the fraud division any employer that repeatedly fails to provide workers' compensation insurance or benefits.

To ensure that it effectively targets employers in industries with the highest incidence of unlawfully uninsured employers, the DLSE should establish a program that uses data from the Uninsured Employers Fund, the Employment Development Department, and the rating bureau, as required by law.

To provide a mechanism to allow reporting of suspected medical provider fraud, the DWC should implement the fraud-reporting protocols required by law.

To help deter workers' compensation fraud, the DWC should warn participants in the workers' compensation system of the penalties of fraud, as required by law.

To avoid overcharging the State's insured employers for the workers' compensation fraud assessment, Industrial Relations should work with the rating bureau to improve the accuracy of the projected premiums for the current year, which it uses to calculate the fraud assessment surcharge ratio provided to workers' compensation insurers for collecting the surcharge from insured employers.

To make certain that insurers do not withhold any portion of the fraud assessment surcharge, Industrial Relations should seek the authority and establish a method to verify that insurers report and submit the workers' compensation fraud assessment surcharge they collect from employers.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: April 29, 2004

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APPENDIX A

Recommendations From Various Entities for Antifraud Grants to District Attorneys

Table A.1, on the following page lists the funding recommendations for fiscal year 2003–04 from the entities involved in the process of awarding workers' compensation fraud assessment funds to county district attorneys. As we discussed in Chapter 1, to be eligible for grants of fraud assessment funds to enhance investigation and prosecution of workers' compensation fraud, each interested district attorney must submit an application.

The first two columns in the table list the county district attorneys who applied for funding as well as the amount of funding requested in each application. Once it receives these applications, the Department of Insurance's Fraud Division (fraud division) reviews each application and develops a recommended funding level for each district attorney. These recommendations are shown in the third column of the table. The fraud division presents its recommendations to the review panel, which is charged with reviewing grant applications from the county district attorneys and providing funding recommendations to the insurance commissioner. The review panel recommendations shown in the fourth column of the table indicate that in 19 cases, the review panel agreed with the fraud division's recommendations.

Before distributing the funds, the insurance commissioner must determine, with the advice and consent of the Fraud Assessment Commission (fraud commission), the most effective distribution of the assessed funds. These figures appear in the table's fifth and sixth columns, respectively. Neither the insurance commissioner in his recommendations nor the fraud commission when giving its advice and consent altered the recommendations of the review panel. Therefore, each county district attorney was awarded the amount shown in the last column for fiscal year 2003–04.

TABLE A.1

Recommendations for Awarding Fraud Assessment Funds for Fiscal Year 2003–04

County District Attorney	Requested Amount	Fraud Division Recommendation	Review Panel Recommendation	Insurance Commissioner Recommendation	Fraud Assessment Commission Advice and Consent	Final Award
Alameda	$ 1,428,081	$ 950,000	$ 1,000,000	$ 1,000,000	$ 1,000,000	$ 1,000,000
Amador	227,000	100,000	85,000	85,000	85,000	85,000
Butte	320,000	50,000	81,000	81,000	81,000	81,000
Contra Costa	556,718	350,000	375,000	375,000	375,000	375,000
El Dorado	51,129	43,000	43,000	43,000	43,000	43,000
Fresno	948,388	700,000	700,000	700,000	700,000	700,000
Imperial	42,736	20,400	42,736	42,736	42,736	42,736
Kern	324,342	300,000	324,000	324,000	324,000	324,000
Kings	202,616	100,000	80,000	80,000	80,000	80,000
Los Angeles	6,322,485	4,300,000	4,300,000	4,300,000	4,300,000	4,300,000
Marin	228,390	145,000	145,000	145,000	145,000	145,000
Mendocino	22,199	21,111	21,111	21,111	21,111	21,111
Merced	86,557	50,000	41,156	41,156	41,156	41,156
Monterey	258,848	210,000	210,000	210,000	210,000	210,000
Orange	1,593,920	1,100,000	1,050,000	1,050,000	1,050,000	1,050,000
Plumas	5,430	5,164	5,164	5,164	5,164	5,164
Riverside	747,623	550,000	500,000	500,000	500,000	500,000
Sacramento	1,018,764	900,000	900,000	900,000	900,000	900,000
San Bernardino	1,063,396	900,000	850,000	850,000	850,000	850,000
San Diego	3,695,698	2,700,000	2,648,565	2,648,565	2,648,565	2,648,565
San Francisco	857,070	700,000	675,000	675,000	675,000	675,000
San Joaquin	499,958	350,000	350,000	350,000	350,000	350,000
San Luis Obispo	63,852	60,721	60,721	60,721	60,721	60,721
San Mateo	461,424	300,000	300,000	300,000	300,000	300,000
Santa Barbara	212,048	150,000	150,000	150,000	150,000	150,000
Santa Clara	1,300,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Santa Cruz	118,013	90,000	90,000	90,000	90,000	90,000
Shasta	271,000	135,000	151,500	151,500	151,500	151,500
Siskiyou	15,098	11,000	6,443	6,443	6,443	6,443
Solano	97,867	93,068	93,068	93,068	93,068	93,068
Sonoma	392,084	130,000	175,000	175,000	175,000	175,000
Stanislaus	274,265	274,265	274,265	274,265	274,265	274,265
Tehama	13,397	13,397	13,397	13,397	13,397	13,397
Tulare	268,748	150,000	150,000	150,000	150,000	150,000
Ventura	482,182	339,000	400,000	400,000	400,000	400,000
Yolo	166,795	140,742	140,742	140,742	140,742	140,742
Totals	**$24,638,121**	**$17,431,868**	**$17,431,868**	**$17,431,868**	**$17,431,868**	**$17,431,868**

APPENDIX B

The Fraud Division's Referral Form for Suspected Fraudulent Claims

The fraud referral form shown in Figure B.1 on the following pages is completed by insurers, informants, witnesses, law enforcement agencies, and Department of Insurance's Fraud Division (fraud division) investigators to report suspected fraudulent activity. After the fraud division receives a referral form and catalogs it in a database, supervisors review the form and inform the insurer that sent the referral about the disposition of the referral. Specifically, the supervisor will tell the insurer whether the referral will be opened for investigation, needs additional information, or will be closed for various reasons including insufficient evidence.

FIGURE B.1

SFC Referral Form (FD-1)

California Department of Insurance **Fraud Division**

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

CDI USE ONLY

Case #: _____ **County Code:** _____ **SFC #:** _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER

REPORTING REQUIREMENTS: Please print legibly or type. California Insurance Code (CIC) § 1872.4 requires companies licensed to write insurance in California to submit this form **WITHIN 60 DAYS** after determining that a claim appears to be fraudulent. CIC § 1877.3 further requires reporting of suspected fraudulent Workers' Compensation claims to **BOTH** the CDI Fraud Division and the local District Attorney's Office **WITHIN 30 DAYS**.

SECTION I. REPORTING PARTY INFORMATION CODE

FRAUD TYPE CODE: _____ REPORTING PARTY CODE: _____ CHECK ONE: ☐ NEW REFERRAL ☐ AMENDED REFERRAL

REPORTING PARTY: _____ (Last Name) _____ (First Name) _____ (MI) _____ (Certificate of Authority (CA) #:) _____ (Self-Insured/TPA#:)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS (IF APPLICABLE): _____

SECTION II. LOSS/INJURY INFORMATION

ALLEGED VICTIM: _____ (Last Name) _____ (First Name) _____ (MI) _____ (Certificate of Authority (CA) #:) _____ (Self-Insured/TPA#:)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CLAIM #: _____ POLICY #: _____ DATE OF LOSS/INJURY: / /

ADDRESS OR LOCATION WHERE LOSS / INJURY OCCURRED:

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PREMIUM LOSS: _____ POTENTIAL LOSS: _____ ACTUAL PAID TO DATE: _____ SUSPECTED FRAUDULENT LOSS TO DATE: _____

SECTION III. SUSPECTED FRAUDULENT CLAIM ACTIVITY

SYNOPSIS: State the facts (who, what, when, where, how, why) that support your suspicion of fraudulent claim activity including any material misrepresentation(s). **Provide details regarding any prior history of fraudulent insurance claim activity by any of the parties. If known, include relevant claim numbers** Attach additional summary sheets if needed.

You may include attachments documenting the suspected fraudulent activity. If a complete copy of the claim file has been submitted to the District Attorney's Office, please attach a complete copy to this Form FD-1. Otherwise, a complete copy of your claim file is not required.

DISASTER CLAIMS: If this suspicious activity is related to a major natural or non-natural disaster, check the box below that best describes the related event:

☐ EARTHQUAKE ☐ FLOOD ☐ FIRESTORM ☐ WIND ☐ OTHER NATURAL ☐ NON-NATURAL (MAN-MADE)

SECTION IV. REPORTS TO OTHER AGENCIES

☐ OTHER LAW ENFORCEMENT AGENCY (specify name): _____

☐ DISTRICT ATTORNEY'S OFFICE (specify name): _____

☐ NICB ☐ OTHER: _____

SECTION V. CONTACT INFORMATION

CONTACT (name/title): _____ PHONE: ( ) _____

FILE HANDLER (if different): _____ PHONE: ( ) _____ DATE FORM COMPLETED:

COMPLETED BY (if different): _____ PHONE: ( ) _____ / /

Mail completed forms to: CDI Fraud Division Intake Unit, P.O. Box 277320, Sacramento CA 95827-7320

FD-1 (rev. 11/02) Page 1 of 3

California Department of Insurance **Fraud Division**

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

Parties to the Loss/Injury

CDI USE ONLY

Case #: _____ **County Code:** _____ **SFC #:** _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER

Claim #: _____ Policy #: _____ Date of Loss/Injury: __/__/__

SECTION VI. INSURED/EMPLOYER INFORMATION (Party A)

PARTY A. ☐ INSURED ☐ EMPLOYER (CHECK ONE/If Workers' Compensation, must show employer here.)

Name: _____ (Last Name / First Name / MI) Phone #: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY B. ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY C. ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY D. ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY E. ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

FD-1 (rev. 11/02) Page 2 of 3

continued on next page

California Department of Insurance **Fraud Division**

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

Parties to the Loss/Injury (continued)

CDI USE ONLY

Case #: _____ **County Code:** _____ **SFC #:** _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER

Claim #: _____ Policy #: _____ Date of Loss/Injury: / /

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY . ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: ( )
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: ( )
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: ( )
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: ( )
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY . ☐ **(Enter party code in box)**

Name: _____ (Last Name / First Name / MI) Phone #: ( )
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

If you need to report more parties to the loss, please complete and attach additional copies of this page as needed.

FD-1 (rev. 11/02) Page 3 of 3

Agency's comments provided as text only.

Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, California 95814

April 13, 2004

Ms. Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: BSA Audit 2002-018: Workers' Compensation Fraud: Response to Final Report

Dear Ms. Howle:

The California Department of Insurance has reviewed the Bureau of State Audits' draft report entitled, "Workers' Compensation Fraud: Detection and Prevention Efforts Are Poorly Planned and Lack Accountability." The audit is a retrospective review of the fraud program as administered by several previous insurance commissioners and includes the first twelve months of my current term in office.

When I assumed office in 2003, one of my greatest challenges was the workers' compensation crisis facing California. Employers faced with escalating premiums were particularly concerned about reducing workers' compensation fraud. Although difficult to quantify, fraud does have a significant impact on the effectiveness of the system.

Therefore, one of my first acts was to reorganize and reenergize the fraud investigation efforts of this Department. We reorganized the Fraud Division, assigned a new director, Dale Banda, and created a special Workers' Compensation bureau naming Kathy Scholz to coordinate our statewide efforts. We directed our Fraud Division to focus on workers' compensation fraud and we prioritized cases to maximize the investigative and enforcement aspect of our efforts and improve coordination with district attorneys. We also worked to enhance the deterrent effect that publicizing arrests and prosecutions has on potential offenders.

During the 2003 legislative session, working with the legislature and the Governor, we were able to enact a number of significant medical cost containment reforms by establishing fee schedules and utilization controls. While these structural changes will result in savings of approximately $5 billion and will reduce the opportunities for abuse and fraud through simplification and clarification of the statute, more fundamental reform is needed.

* California State Auditor's comments begin on page 131.

An equally important component of our fraud efforts is my goal to strengthen the criminal penalties for fraud and to expand immunity from liability for those who report fraud. I have requested that these anti-fraud measures be addressed during the special legislative session.

I appreciate the thoroughness of the Bureau of State Audits' report. It describes a number of findings and recommendations that we also identified and have acted upon this past year. Please see our overview and response to the recommendations.

We look forward to describing our specific progress in making further changes over the next year.

Sincerely,

(Signed by: John Garamendi)

John Garamendi
Insurance Commissioner

California Department of Insurance
Response to the Bureau of State Audit Report 2002-18
Workers' Compensation Fraud: Detection and Prevention Efforts Are Poorly Planned and Lack Accountability

Response Overview

Introduction--Bureau of Fraudulent Claims (Fraud Division)

In evaluating the audit findings, we must start with the statutory mandate for the investigation of fraudulent claims. California Insurance Code section 1872.83(a) states that "The commissioner shall ensure that the Bureau of Fraudulent Claims (Fraud Division) aggressively pursues all reported incidents of probable workers' compensation fraud…." In the 25-year existence of the Division, it has fulfilled this statutory responsibility by accepting all probable or "suspected fraud" referrals from insurers, evaluating each referral and prioritizing investigations based on the evidence and available resources. In 2003 insurer premium for workers' compensation insurance coverage approximated $21 billion. For 2003-04, the cost of the Department's effort to investigate and prosecute fraud amounted to $34.5 million or .164 percent of total insurer premium.

Over the past five reported years, the combined local and state fraud program costs were $150,492,500 compared to the $550,223,978 in chargeable fraud prosecuted during this same period. It should be noted that chargeable fraud is a figure that represents the amount the prosecutor believes can be proven in court. This figure is often far less than the actual fraud committed. With respect to this five year history, the return on investment has been $3.65 for each dollar spent by the program. Not as simple to measure, but even more important is the deterrent value of publicizing successful fraud investigations and prosecutions. For example, after a significant applicant fraud case was prosecuted involving the Los Angeles County Metropolitan Transit Authority (MTA) and an anti-fraud awareness campaign was conducted, the rate of workers' compensation claims there fell by 29% compared to the preceding year.

Measuring fraud

The auditors criticize the program for not having a baseline measure of the incidence of fraud in the workers' compensation system. They argue that the absence of such a baseline hampers the Department's ability to plan, deploy resources and ensure accountability. The Department agrees that valid estimates of the incidence of workers' compensation fraud would be useful and could aid in resource allocation. However, implicit in the auditor's statements is an incorrect assumption, i.e. that an increase in fraud enforcement efforts alone will reduce the incidence of fraud or the fraud rate.

A variety of other factors are equally or more determinative of the incidence of fraud at any given time. For example, applicant fraud is likely to rise during recessions, where employees face the possibility of layoffs or have lost their jobs. Similarly, a hardened market for workers' compensation insurance will increase the occurrence of premium fraud as well as the number of willfully uninsured employers. Finally, the complexity of the current law invites claim abuse by medical providers. Each of these factors impacts the incidence of fraud independent of increased or decreased enforcement efforts.

As noted earlier, the Department acknowledges the value of measuring the incidence of fraud to gauge the impact of fraud investigations and prosecutions. Therefore, the Department identified related research in preparation for engaging a study. The recurring theme of this research was the difficulty in measuring fraud and the recognition that no directly relevant studies have been undertaken. The auditors acknowledge these difficulties and suggest the experience of the Internal Revenue Service and the Centers for Medicare and Medicaid Service can serve as an approach we may wish to examine. We note that both of these federal agencies have robust databases from which to mine relevant data. The California workers' compensation system does not currently have a comprehensive database for such research; however, we are discussing with the Workers' Compensation Insurance Rating Bureau of California and the California Workers' Compensation Institute how to gain access to their data sources in order to pursue this research.

Planning

The Bureau of State Audits (BSA) identified a lack of strategic planning. After taking office, we recognized the need for the Department to develop more results oriented business plans. Every unit in the department, including the Fraud Division has taken the first steps in producing such plans. These new plans identify goals, objectives and action plans consistent with vision and strategic initiatives the Commissioner has articulated.

The current business plan was initiated in 2003. The Fraud Division continues to refine its initial plan based on trend information it obtains from "suspected fraud" referrals, data from other governmental agencies, district attorneys and through collaborative meetings with the Fraud Assessment Commission (FAC) and other stakeholders.

In 2003, the Fraud Division commenced reporting on its findings through the use of measurements such as the number of suspected fraud referrals evaluated, case investigations and case completions. It will report result-measures such as the number of convictions, restitutions, fines, regulatory actions, penalties, and return on investment as part of its 2004-05 plans.

Awarding and monitoring grants

BSA states that the grant awards are not determined using established priorities. Contrary to this assertion, the FAC recommends funding for workers' compensation fraud abatement on the basis of guidelines and criteria set forth in the California Insurance Code (CIC) Section 1872.83(b)(4) and 10 California Code of Regulations Section 2698 et seq. Notably, neither the CIC nor the CCR permit the use of alternate criteria for suggesting funding levels. A discussion of the codified criteria is included in the Appendix.

The Department recognizes that the statute does allow it to amend the regulations to place more emphasis on district attorney performance as a basis for grant award. In keeping with the BSA's recommendation, the Department will amend the regulations to improve the award process, grant management, and independent auditing requirements.

Insurer standards for reporting suspected fraud and compliance

BSA has stated that the Fraud Division could more effectively manage its investigative efforts if the standard of evidence required in the insurer referral process was strengthened. As described previously, CIC section 1872.83(a) mandates the Commissioner to accept and pursue all reported incidents of probable workers' compensation fraud. It is important that all insurers submit all suspected fraudulent claims for trend analysis and for setting priorities. This information often identifies a pattern of criminal activity that otherwise would go undetected.

Under the current statutory referral criteria, we must evaluate all case referrals. The auditors identified approximately 84 percent of investigative time did result in case submission to a prosecutor. Cases are selected based on the best probability for prosecution, however, every case has uncertainties. Therefore, we do not believe that a 16% case closure rate is excessive, but rather acceptable.

The Division agrees that improvements can be made in the quality and consistency of insurer referrals. To this end, emergency regulations were adopted on September 4, 2003. These regulations are now being refined through a formal process involving insurers and other stakeholders. Permanent regulations are scheduled for adoption in October 2004.

We welcome the comments of the BSA as an opportunity to build on this foundation and to continue to improve the cost effectiveness of our program.

Provided below are specific comments addressing each audit report recommendation.

Chapter One
Recommendation 1:

Revamp its decision-making process so that it includes the best information available, including the results of the Department of Insurance's analyses of the nature and extent of fraud in the Workers' Compensation system once they are completed, the effectiveness of prior years' efforts

to reduce fraud on the part of the fraud division and district attorneys that are linked to their respective program objectives, and any newly emerging trends in fraud schemes that should receive more attention.

Response to recommendation:

The Department of Insurance concurs-in part: The Department believes BSA has not given adequate consideration to the complexity of analyzing the nature and extent of fraud in the workers' compensation system. However, the Department has been working with the new chairman of the Fraud Commission to develop a strategy to improve the efficiency, consistency and accountability in the decision-making process. The Department, along with the District Attorneys, will work with the commission to provide the best information available on reported fraud and trends; continue with round-table discussions pertaining to anti-fraud efforts; and make adjustments to program objectives focused on reducing fraud.

Recommendation 2:

Request an annual proposal from the fraud division that outlines its objectives and measurable outcomes linked to its objectives from the prior year and its objectives for the ensuing year, and the expenditures planned by the fraud division to accomplish those objectives.

Response to recommendation:

The Department of Insurance concurs: The Department will work closely with the Fraud Commission so that its vision, objectives, and priorities align with the Insurance Commissioner's strategic initiatives. The Department will amend its Business Plan and internal processes consistent with the FAC and Insurance Commissioner's priorities.

Recommendation 3:

Request, in addition to the information currently required of each county district attorney planning to participate in the program, a report listing the district attorney's accomplishments in achieving the goals and objectives outlined in the prior year's application and the goals and objectives for the ensuing year and the estimated cost of the year's activities to achieve them, along with a description of how those goals and objectives align with the program goals described by the fraud commission and insurance companies.

Response to recommendation:

The Department of Insurance concurs: The Department intends to amend the relevant regulations and will be presenting funding guidelines to the FAC that focus on district attorney performance, past and future.

Recommendation 4:

Develop and implement a process for awarding fraud assessment grants that provides consistency among those making funding recommendations by incorporating standard decision-making criteria and a rating system that supports funding recommendations.

Response to recommendation:

The Department of Insurance concurs: The Department will adopt amended regulations that base awards on measurable performance criteria. But in keeping with statute and case law, the members of the FAC can consider additional information in making their funding decisions.

Recommendation 5:

Include in the decision-making criteria how well the county district attorneys' proposals for using the assessment funds align with the strategy and priorities developed by the fraud commission and the Insurance Commissioner, as well as the district attorneys' effectiveness in meeting the prior year's objectives.

Response to recommendation:

The Department of Insurance concurs: The Request for Funds Application (RFA) is being revised to provide greater focus on performance. The amended RFA will ask the district attorneys to address their performance and caseload priorities. The district attorneys will be required to describe prior year's accomplishments as well as proposed plans to meet the objectives identified by the Insurance Commissioner and the FAC.

Recommendation 6:

Document the rationale for how decisions on recommendations for grant awards are made.

Response to recommendation:

The Department of Insurance concurs: The Department will adopt procedures to document the decision process.

Recommendation 7:

Reevaluate the Department of Insurance regulations pertaining to how indirect costs are charged to fraud assessment grants to determine whether the regulations provide the desired amount of control, and seek changes in the regulations if required, and ensure that all county district attorneys that apply for fraud assessment grants disclose their method of charging indirect costs.

Response to recommendation:

The Department of Insurance concurs: The Department will amend the regulations to clarify allowable indirect costs.

Recommendation 8:

Change its past policy of awarding the base portion of fraud assessment grants to county district attorneys exclusively on whether they submitted a completed application by the required deadline and instead make recommendations for grant awards, including the base allocations, on evaluations of county district attorneys' plans that include how the funds will be used, as required by Department of Insurance regulations.

Response to recommendation:

The Department of Insurance concurs: The Department will amend the regulations to the extent the law allows, to better ensure that fraud assessments are distributed to district attorneys who most effectively investigate and prosecute workers' compensation fraud

Recommendation 9:

Determine whether the provisions of the Bagley-Keene Open Meeting Act apply to the review panel's meetings to recommend fraud assessment grants to county district attorneys and, if it does, seek a specific exemption for discussions of those portions of the county district attorneys' applications for grant awards that include confidential criminal investigation information while keeping those parts of the meeting discussing recommendations for district attorney funding levels open to the public and ensure that the review panel complies with the requirements.

Response to recommendation:

The Department of Insurance is currently reviewing the applicability of the Bagley-Keene Act to the Review Panel process as codified by 10 CCR 2698 et.seq. and if appropriate the Department shall request legal guidance from the Attorney General.

Recommendation 10:

Continue current efforts to establish performance measures that can be used to evaluate the effectiveness of the fraud division and participating district attorneys in reducing workers' compensation fraud. Such measures can also assist in determining the appropriate amount of funds to be assessed and divided between the fund division and grants for county district attorneys. Finally, these measures could assist in arriving at a recommendation for individual grant awards to the county district attorneys and the fraud division.

Response to recommendation:

The Department of Insurance concurs: Shortly after taking office, the Insurance Commissioner directed the Fraud Division to develop a Business Plan that would align with the Department's vision, goals and strategic initiatives. In developing the Business Plan, the Fraud Division considered its internal strengths, weaknesses, and past performance. The Fraud Division acknowledges the need to address performance measures both internally (investigations) and externally (prosecutions) within its Business Plan and will be working with the FAC, District Attorneys and other stakeholders to accomplish this result.

Chapter 2
Recommendation 11:

In addition to investigating fraud, the fraud division should recognize its other responsibilities, including advising the fraud commission and the Insurance Commissioner using documented past performance and future projections on the optimum annual amount of aggregate assessment needed by the program to fight workers' compensation fraud and the most effective distribution of the funds assessed to investigate and prosecute workers' compensation fraud and reporting on the economic value of insurance fraud and making recommendations to reduce it.

Response to recommendation:

The Department of Insurance concurs: The Department will allocate resources to address fraud research, trends analysis, and effective funding disbursement methods, and improved oversight of county grants. The Department will also reactivate an advisory committee made up of stakeholders dedicated to fighting workers' compensation fraud to provide input about the affects of fraud and suggest priorities for reducing it.

Recommendation 12:

After recognizing its responsibilities, modify its business plan to meet those responsibilities, including establishing appropriate goals and objectives, activities, and priorities.

Response to recommendation:

The Department of Insurance concurs: (See response on recommendation 10.)

Recommendation 13:

The fraud division should establish benchmarks that it can use to measure its and district attorneys' performance in meeting goals and objectives, and to determine whether the program is operating as intended and resources are appropriately allocated.

Response to recommendation:

The Department of Insurance concurs: (See response on recommendation 10.)

Recommendation 14:

To fulfill its non-investigative roles, the fraud division should realign its resources to maintain an adequate effort to conduct the research necessary to fulfill its statutory role as an advisor regarding the level of funding and the direction of fraud reduction efforts, including efforts to measure the nature and extent of fraud in the workers' compensation system and the effect of antifraud efforts, monitor the performance of county district attorneys who receive grants of fraud assessment funds, and conduct the research necessary to meet its advisory and reporting responsibilities.

Response to recommendation:

The Department of Insurance concurs with this recommendation: (See recommendation 11.)

Recommendation 15:

Reevaluate its suspected fraud reporting process to identify the type of referrals and level of evidence it requires in those referrals to reduce the number of hours it spends on referrals that ultimately do not result in submittal to county district attorneys for prosecution.

Response to recommendation:

The Department of Insurance concurs-in part: The current relevant statutes include: California Insurance Code section 1872.4 mandates that insurers refer all suspected fraudulent claims to the Department; California Insurance Code 1872.83(a) mandates the commissioner shall ensure that the Bureau of Fraudulent Claims aggressively pursues all reported incidents of probable workers' compensation fraud; and California Insurance Code 1877.3(b)(1) mandates that when an insurer knows or reasonably believes it knows the identity of a person or entity whom has reason to believe committed a fraudulent act relating to a workers' compensation insurance claim or a policy shall notify the local district attorney's office and the Bureau of Fraudulent Claims of that suspected fraud and provide the basis of the suspected fraud.

While the Department will reevaluate its referral process and evidence standards, this will be done within the context of existing statutes. The Department believes it is important that all insurers submit all suspected fraudulent claims for trend analysis and the establishment of priorities. This information often identifies a pattern of criminal activity that otherwise would have gone undetected. In accordance with BSA's recommendation the Department will review internal procedures in an attempt to reduce the number of hours that do not result in a case submission to prosecutors.

Recommendation 16:

Clarify its expectations for the independent audits by seeking a change in the Department of Insurance regulations that require audit reports to provide an opinion on county district attorneys' level of compliance with key provisions of the applicable laws, regulations, and terms of the fraud assessment grants.

Response to recommendation:

The Department of Insurance concurs: The Department will amend the regulations to clarify the independent audit requirements.

Recommendation 17:

Ensure the county district attorneys comply with the independent audit requirements and promptly submit their audit reports.

Response to recommendation:

The Department of Insurance concurs: Compliance with the submittal of the independent audit reports will be a condition of continuing funding.

Chapter 3
Recommendation 18:

Clear objectives and priorities that will promote adequate audit coverage of workers' compensation insurers.

Response to recommendation:

The Department of Insurance concurs: (See response recommendation 20.)

Recommendation 19:

Standards for conducting audits of insurers' special investigative units that include audit objectives, audit procedures, methodologies for sampling claims transactions, appropriate audit evidence, and supervision of the audits.

Response to recommendation:

The Department of Insurance concurs: (See response recommendation 20.)

Recommendation 20:

Issue its audit reports promptly and periodically follow up on audit findings. Also develop equitable methods of enforcing compliance with the fraud reporting requirements.

Response to recommendation:

The Department of Insurance concurs: The Department is developing a standardized approach to insurer audits that will allow us to target insurers and achieve maximum compliance with reporting requirements.

Appendix

Grant Awards

The following supplements the "Awarding and Monitoring Grants" section of the main text found on page 3.

CCR Section 2698 elucidates general funding procedures for distribution of special funds established by CIC 1872.83(b) (4).[i] CCR Section 2698.53 identifies such funding as a "grant award".[ii] CCR Section 2698.54 apportions "grant awards" into two categories, dictates the percentage of CIC Section 1872.83(b)(4) funds that shall be directed at each, mandates that participating district attorneys submit "county plans", and requires fund distribution to be based thereon.[iii] CCR Section 2698.55 defines the necessary elements of a "county plan".[iv] Finally, CCR Section 2698.57 establishes the overall criteria to be used in determining funding and permits funding despite inadequate county plans given the importance of combating workers' compensation fraud.[v]

Thus the rationale used by the Review Panel to distribute funds is already codified and requires no further description or explanation. As noted previously, no authority exists for the Review Panel to form a recommendation based on criteria other than that which is codified. Recommending funding despite an inadequate "county plan" can be permissible given a known presence of workers' compensation fraud or the need to establish an abatement effort in the area.

To the extent that Review Panel members must interpret performance and need based on the mandated criteria, each is afforded great discretion and unless shown to be arbitrary & capricious, courts shall uphold such interpretations and refuse to intervene.[vi] Moreover, courts presume the legitimacy of such interpretation and the complainant carries the burden of establishing otherwise.[vii]

Insurer Referrals

The following supplements the "Insured standards for reporting suspected fraud and compliance" section of the main text found on page 3.

The Legislature, through CIC Section 1871 declared workers' compensation fraud abatement to be a high priority as the effects of such fraud are harmful to the state, its economy and a burden to California taxpayers.[viii] As a result, the Legislature requires that suspicions, evens those based on little evidence be pursued. Specifically, the Legislature mandates, through CIC 1872.4, that insurers refer all suspected fraudulent claims to the DOI unless statutorily specified circumstances exist and that the DOI investigate all such referrals.[ix]

Additionally, the Legislature, through CIC 1872.3, mandates that the DOI, specifically its Fraud Division, investigate all suspected instances of fraud[x]. Thus it is the Legislature that has purposefully created a low evidentiary standard for the investigation and prosecution of these frauds. The reasoning being a historical failure by insurers to refer such matters and the importance of abating workers' compensation fraud.

[i] "These regulations are promulgated pursuant to authority granted to the Insurance Commissioner under the provisions of Section 1872.83 of the California Insurance Code. The purpose of these regulations is to set forth the criteria for distribution of funds to district attorneys for enhanced investigation and prosecution of workers' compensation insurance fraud cases, including an application process and subsequent reporting requirements."

[ii] 10 CCR 2698.53 states, in pertinent part,
"(a) Funding shall be in the form of a Grant Award Agreement and shall require an enabling resolution approving and authorizing execution of the agreement by the county Board of Supervisors.

[iii] CCR Section 2698.54 states, in pertinent part,
"Each district attorney's allocation shall consist of two parts: a base allocation and a program award, both made as a result of the evaluation of the county plans. The base allocation shall be made from fifty percent (50%) of the total funds and allocated according to the following "caseload estimate", an estimate of the district attorney's proportional share of the state's workers' compensation fraud investigation and prosecution caseload:
(a) The county's proportion of the state's annual average number of workers engaged in wage and salary employment for the most recent year of report shall receive the greatest weight and shall account for sixty-six percent (66%) of the base allocation funding. The employment data source is the Employment Development Department Annual Planning Information.
(b) The county's proportion of the state's workers' compensation suspected fraudulent claims as reported to the California Department of Insurance over the previous three years shall account for thirty-four percent (34%) of the base allocation funding. The source for data on the number of suspected fraudulent claims reported to the Division is the California Department of Insurance.

[iv] CCR § 2698.55 states, in pertinent part,
The County Plan shall include but need not be limited to the following elements detailing the county's qualifications and the manner in which the district attorney will use the funds to investigate and prosecute workers' compensation insurance fraud:
(a) Qualifications.
(1) A description of the district attorney's experience in investigating and prosecuting workers' compensation insurance fraud. Relationships with other public or private entities which may be useful to the program should also be included. Specific activity during the past two years should be detailed as follows:
(A) Number of investigations initiated, specifying number of identified suspects per investigation;
(B) Number of warrants or indictments issued, specifying number of suspects and/or defendants;
(C) Number of arrests made;
(D) Number of convictions obtained, specifying number of defendants, number obtained by trial verdict and number obtained by plea or settlement;
(E) Amount of fines and penalty assessments ordered and collected, specifying number of defendants; and

(F) Amount of restitution ordered and collected, specifying number of defendants and victims.
(2) The panel shall consider each applicant county's population size in proportion to its historic commitment of resources to insurance fraud investigation and prosecution.
(b) Plan. The district attorney's plan for investigation and prosecution of workers' compensation fraud, including, at a minimum, the following elements:
(1) Problem Statement. A description of the extent and nature of the problem in the county, including its sources and causes, its economic and social impact, its unique aspects, if any, and what is needed to resolve the problem. Supporting data, evidence, or indicators of fraudulent activity related to workers' compensation insurance should be included. The data and information may be derived from third party administrators, self-insured employers, other local law enforcement entities, insurers or the Fraud Division or the Investigation Bureau of the California Department of Insurance.
(2) Program Strategy. This section shall specify how the district attorney will use program funds to address the problem defined above including:
(A) Outreach. A description of the manner in which the district attorney will develop his or her caseload, the source(s) for referrals of cases for investigation and/or prosecution, whether directly from the Division and/or directly from self-insured employers, third-party administrators and insurers or a combination;
(B) Personnel. The number, position titles and position justification of personnel to be funded fully or in part through grant funds, including descriptions of the qualifications of personnel to be assigned to the program and an organization chart identifying positions to be funded;
(C) Program Coordination. A description of the manner in which the district attorney plans to coordinate involved sectors, including employers, insurers, medical and legal provider communities, the Fraud Division and the Investigation Bureau of the California Department of Insurance;
(D) Management Plan. The detailed plan and schedule of the steps the district attorney will complete in achieving the objectives of the program and a discussion of how the program will be organized and what internal quality control and budget monitoring procedures will be employed. This part should also include how this program will be integrated with any other anti-fraud program(s) maintained within the district attorney's office;
(E) Staff Development. The plan for ongoing training of personnel on the workers' compensation system and the investigation and prosecution of fraud. Staff development may be addressed through coordination with the Division insurers or other entities.
(3) Objectives. This section shall outline the district attorney's anticipated achievements in the following areas:
(A) Estimated number of investigations to be initiated during the grant period, including a separate estimate of the number resulting from carryover investigations; and
(B) Estimated number of prosecutions to be initiated during the grant period.

[v] CCR § 2698.57 states,

Based on the Review Panel's evaluation of each County Plan, the Panel will forward funding recommendations to the Commissioner. If the County Plan fails to respond adequately to the required items as specified in Sections 2693.6 and 2693.7, the Panel may recommend funding at the district attorney's base allocation level; however, the Panel shall consider the importance of establishing a program presence in a county to increase community awareness and deter workers' compensation fraud. However, Applications which fail to meet the specified criteria may be recommended for no funding.

[vi] "the construction of a statute by officials charged with its administration... is entitled to great weight" (Morris v. Williams, 67 Cal. 2d 733, 748 [63 Cal. App. 689, 433 P.2d 697]), and "if there appears to be some reasonable basis for the classification, a court will not substitute its judgment for that of the administrative body" (Rible v. Hughes, 24 Cal. 2d 437, 445 [150 P.2d 455, 154 A.L.R. 137]). "[T]he court should not substitute its judgment for that of an administrative agency which acts in a quasi-legislative capacity. [A court] will not, therefore, superimpose its own policy judgment upon the agency in the absence of an arbitrary and capricious decision." (Pitts v. Perluss, 58 Cal. 2d 824, 832 [27 Cal. Rptr. 19, 377 P.2d 83]; see also Ralphs Grocery Co. v. Reimel 69 Cal. 2d 172, 179 [70 Cal. Rptr. 407, 444 P.2d 79].) "If reasonable minds may well be divided as to the wisdom of an administrative board's action, its action is conclusive.' (Rible v. Hughes, supra, at p. 445.)' "... Courts and commentators have therefore centered their attention on an assurance of judicial abstention in areas in which the responsibility for basic policy decisions has been committed to coordinate branches of government. Any wider judicial review, we believe, would place the court in the unseemly position of determining the propriety of decisions expressly entrusted to a coordinate branch of government. Moreover, the potentiality of such review might even in the first instance affect the coordinate body's decision-making process...." (Id.) We conclude that the decision making process of the commission and the regional commissions in granting or denying a coastal development permit is a task involving basic policy decisions of the type contemplated by the Johnson case discussion, and therefore is a discretionary act within the meaning of the Tort Claims Act. Also see "... Courts and commentators have therefore centered their attention on an assurance of judicial abstention in areas in which the responsibility for basic policy decisions has been committed to coordinate branches of government. Any wider judicial review, we believe, would place the court in the unseemly position of determining the propriety of decisions expressly entrusted to a coordinate branch of government. Moreover, the potentiality of such review might even in the first instance affect the coordinate body's decision-making process...." (Id.)

[vii] In addition, it has been said that an administrative ruling 'comes before the court with a presumption of correctness and regularity, which places the burden of demonstrating invalidity upon the assailant [fn. omitted].' (California Assn. of Nursing Homes etc., Inc. v. Williams, 4 Cal. App. 3d 800, 810 [84 Cal. Rptr. 590, 85 Cal. Rptr. 735].)"

[viii] In pertinent part, CIC 1871 states, (d) Workers' compensation fraud harms employers by contributing to the increasingly high cost of workers' compensation insurance and self-insurance and harms employees by undermining the perceived legitimacy of all workers' compensation claims.

(e) Prevention of workers' compensation insurance fraud may reduce the number of workers' compensation claims and claim payments thereby producing a commensurate reduction in workers' compensation costs. Prevention of workers' compensation insurance fraud will assist in restoring confidence and faith in the workers' compensation system, and will facilitate expedient and full compensation for employees injured at the workplace.

(f) The actions of employers who fraudulently underreport payroll or fail to report payroll for all employees to their insurance company in order to pay a lower workers' compensation premium result in significant additional premium costs and an unfair burden to honest employers and their employees.

(g) The actions of employers who fraudulently fail to secure the payment of workers' compensation as required by Section 3700 of the Labor Code harm employees, cause unfair competition for honest employers, and increase costs to taxpayers.

[ix] CIC § 1872.4. Notice by insurer of belief that fraudulent claim being made

(a) Any company licensed to write insurance in this state that believes that a fraudulent claim is being made shall, within 60 days after determination by the insurer that the claim appears to be a fraudulent claim, send to the Bureau of Fraudulent Claims, on a form prescribed by the department, the information requested by the form and any additional information relative to the factual circumstances of the claim and the parties claiming loss or damages that the commissioner may require. The Bureau of Fraudulent Claims shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations. Whenever the commissioner is satisfied that fraud, deceit, or intentional misrepresentation of any kind has been committed in the submission of the claim, he or she shall report the violations of law to the insurer, to the appropriate licensing agency, and to the district attorney of the county in which the offenses were committed, as provided by Sections 12928 and 12930. If the commissioner is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, he or she shall report that determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

(b) This section shall not require an insurer to submit to the bureau the information specified in subdivision (a) in either of the following instances:

(1) The insurer's initial investigation indicated a potentially fraudulent claim but further investigation revealed that it was not fraudulent.

(2) The insurer and the claimant have reached agreement as to the amount of the claim and the insurer does not have reasonable grounds to believe that claim to be fraudulent.

(c) Nothing contained in this article shall relieve an insurer of its existing obligations to also report suspected violations of law to appropriate local law enforcement agencies.

(d) Any police, sheriff, disciplinary body governed by the provisions of the Business and Professions Code, or other law enforcement agency shall furnish all papers, documents, reports, complaints, or other facts or evidence to the Bureau of Fraudulent Claims, when so requested, and shall otherwise assist and cooperate with the bureau.

(e) If an insurer, at the time the insurer, pursuant to subdivision (a) forwards to the Bureau of Fraudulent Claims information on a claim that appears to be fraudulent, has no evidence to believe the insured on that claim is involved with the fraud or the fraudulent collision, the insurer shall take all necessary steps to assure that no surcharge is added to the insured's premium because of the claim.

[x] 1872.3. Investigations; Cooperation with law enforcement agencies

(a) If, by its own inquiries or as a result of complaints, the Bureau of Fraudulent Claims has reason to believe that a person has engaged in, or is engaging in, an act or practice that violates Section 1871.4 of this code, or Section 549 or 550 of the Penal Code, the commissioner in his or her discretion (1) may make those public or private investigations within or outside of this state that he or she deems necessary to determine whether any person has violated or is about to violate any provision of Section 1871.4 of this code, or Section 549 or 550 of the Penal Code, or to aid in the enforcement of this chapter, and (2) may publish information concerning any violation of this chapter or Section 550 of the Penal Code.

COMMENTS

California State Auditor's Comments on the Response From the Department of Insurance

To provide clarity and perspective, we are commenting on the Department of Insurance's (department) response to our audit report. The numbers below correspond to the numbers we placed in the margin of the department's response.

1. We make no such assumption. As we state on page 30, without attempting to measure the nature and extent of the fraud present in the workers' compensation system, it is difficult for the department to justify its current actions to reduce fraud, and it is also difficult to justify any shift in the focus of such efforts.

2. As we state on pages 30 and 31, the department already has sources available that could be used to statistically project the types and extent of fraud present in the workers' compensation system. The department has the ability right now to access the payment databases of all insurers licensed to sell insurance in California, and by reviewing as few as 37 of these databases, would have information on 84 percent of the state's workers' compensation insurance market.

3. As we state on page 34, collecting and publishing discrete statistics of investigations, convictions, restitutions, and other activities and using them as measures of the success of the program's efforts show only that some source of fraud may have been removed from the system, but does not reveal whether antifraud efforts have actually reduced the overall cost that fraud adds to the system.

4. The department missed our point. On pages 34 and 35, we asked the chief of the fraud division if the fraud commission and the insurance commissioner had the authority to set statewide initiatives and priorities to be used as funding criteria for the workers' compensation antifraud program. However, he did not directly answer our question. On pages 43 and 44 we did state that grant awards are not determined using standardized criteria and that neither the review panel nor the fraud division staff document the rationale they use in reaching their respective recommendations for distributing the grant funds.

- The department is misinterpreting what we said. We did not recommend that the standard of evidence in the insurer referral process be strengthened. Rather, we made the observation on page 69 that, according to the department's fraud division's (fraud division) case management database, only 3 percent of the workers' compensation fraud referrals it received from September 2001 through December 2003 were submitted for prosecution, with a large proportion of its closed referrals citing insufficient evidence as the reason for closure. Therefore, it appears that the fraud division does not receive the quality of referrals from insurers it needs to conduct successful investigations.

- The department is mistaken. As depicted in Figure 8 on page 70, the fraud division's investigators spent approximately 33 percent of their time from September 2001 through December 2003 on referrals that were submitted for prosecution, not 84 percent. Furthermore, as shown by Figure 7 on page 69, the rate of case closure for the period we reviewed is 87 percent, not 16 percent.

- We disagree. We believe we give ample consideration to the difficulties in analyzing the nature and extent of fraud in the workers' compensation system and suggest methods to overcome them on pages 28 through 31.

- The department's claim that the rationale used by the review panel to distribute funds is codified and requires no further description or explanation is misleading. Section 2698.55 of the California Code of Regulations specifies those elements that must, at a minimum, be included in the county plan that accompanies a district attorney's application to receive a portion of the workers' compensation antifraud grant funds. Among the elements required to be included in the county plan is a description of the district attorney's experience in investigating and prosecuting workers' compensation fraud, the district attorney's plan for investigating and prosecuting workers' compensation fraud based on a description of the extent and nature of the fraud problem in the county, the district attorney's strategy for using the grant funds to address the county's workers' compensation fraud, and the district attorney's targeted achievements for initiating investigations and prosecutions to be accomplished during the grant period. As we state on page 44, the process used to evaluate the county plans submitted by district attorneys wishing to participate in the program is based on the individual judgments of the members of the review panel using their own personal criteria without documenting the reasons for their decisions. For example, some members

of the review panel may think certain elements contained in a district attorney's county plan are more important than others, but since there is no standard scale that weights the importance of each element, someone independent of the process used by a review panel member could not arrive at the same result.

- We are not recommending that referrals not be investigated. Rather, as we state on page 69, because the fraud division closes so many referrals citing a lack of evidence, it should work with insurers to increase its number of referrals that are submitted for prosecution.

- As we state on page 51, these two sections (Sections 2693.6 and 2693.7) do not exist in department regulations.

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Agency's comments provided as text only.

State of California
Fraud Assessment Commission
William Zachry, Chairman

April 13, 2004

Ms. Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Re: Response to State Audit of the Fraud Commission

My response to the audit is in three sections:

1. General comments and observations concerning the audit
2. Facts and information which is in the audit needing correction
3. A direct response to the audit recommendations

Comments and observations concerning the audit:

I have received a redacted copy of the audit of the Fraud Commission and the DOI Fraud Division. Without a full copy of the audit the Commission will be unable to fully and adequately respond to the findings.

As the newly elected chair of the Commission (December 2003) I took aggressive action to implement changes to improve the effectiveness of the Fraud Assessment Commission and the Fraud Division.

I directed the DOI Fraud Division to work with the district attorneys to develop objective criteria for the Commission to use to evaluate the productivity of the district attorneys.

The Commission intends to use this criterion as one of the measurables, when determining the amount of funding that is required as well as when determining the distribution of funds to the district attorneys and the Fraud Division.

I asked the DOI Fraud Division to submit to the Commission, their budget, and the outline of their goals and expectations for the next fiscal year.

* California State Auditor's comments begin on page 143.

I asked the DOI Fraud Division to review its regulations and current audit process of the insurance SIU operations.

I asked the Fraud Division to obtain a legal opinion to determine if the Bagley-Keene Open Meeting Act applies to the review panel.

The DOI Fraud Division has been working to comply with these instructions.

The Fraud Commission scheduled an open forum (June 2004) of workers compensation stakeholders and vendors (employers, labor representatives, applicant attorneys, medical providers, bill review companies, and brokers). We will use the information from the forum to evaluate and assess the extent of workers' compensation fraud and the changing nature of workers' compensation fraud. We will also obtain information and recommendations on how to improve data collecting, reporting and fighting of fraud in California. We will also use this forum as a way to re-institute the fraud advisory committee.

- The audit did not acknowledge all of the changes or actions taken since the change of leadership of the Commission. Nor did the audit recognize many of the improvements and changes that the Insurance Commissioner has instituted since his election.

- Many of the audit recommendations are initiatives, which are already underway, and I anticipate full implementation of those in a timely basis.

- The fundamental theme of the audit is the need to fully identify the extent and nature of fraud in the workers compensation system. The audit states that unless the full nature and extent of fraud is identified it is difficult to focus resources and it is difficult to measure results. I agree with the concept. Yet in the body of the audit is the statement that fraud, by its nature, is impossible to fully measure. This fundamental conflict detracts the effectiveness of the audit, and its recommendations. The data sources, to identify fraud, recommended in the audit, contain no specific fraud identifiers.

Fraud is an evolving process. The best source of fraud identifiers and trends is the Suspected Fraudulent Claims (SFC) process. Currently, the SFC process is weak because there are different interpretations concerning the mandate on reporting. There is a failure of the legislature to fully provide immunity to all who may report fraud, and because the self-insured community is largely left out of the process, both legislatively and operationally.

- The audit recommendations fails to identify the SFC process as the primary source of potential fraud data, nor does it make recommendations on how to fully engage employers and other stakeholders to report all suspected fraudulent activity.

To effectively fight fraud in California there needs to be a collaborative effort between the employers, insurance carriers, DOI Fraud Division, district attorneys and the Fraud Assessment Commission.

During the past year a number of changes have commenced to improve the planning and cost effectiveness of the anti-fraud program. We have made many good changes and believe that we are on the right road to having a more cost-effective program. More needs to be done and we anticipate a positive impact from recognizing the audit recommendations.

Sincerely,

(Signed by: William M. Zachry)

William M. Zachry, Chair
Fraud Assessment Commission

Fraud Assessment Commission
Response to the Bureau of State Audit Report 2002-18
Workers' Compensation Fraud: Efforts to Detect and Prevent
Workers' Compensation Fraud Are Poorly Planned and Lack Accountability

Response Overview

Technical Corrections
(redacted version supplied to Commission)

pp. 12[1] Permanent disability is a separate benefit from Vocational Rehabilitation. It is technically reimbursement for a reduced capacity to compete in the open job market. In California six out of every ten lost time claims receive permanent disability benefits irregardless of return to work.

pp. 12[1] The state of California is permissibly uninsured.

pp. 13[1] the audit may wish to confirm the $9.5 billion in 1995 and the $25 billion in 2002. There are differing figures and opinions on the size of the total system

pp. 13[1] agents and brokers and unauthorized entities also commit workers compensation fraud

pp. 18[1] The audit may wish to delineate how much the Fraud Division has grown from, and how much of the staff and organization is paid for by the fraud funding.

pp. 20[1] The audit did not mention the 5% funding process in the audit report. That process has specific criteria for allocation of monies to the district attorneys.

pp. 20[1] The audit did not mention or list the Fraud Commissions annual funding cycle calendar.

pp. 22[1] The California State Bar for attorneys, the licensing boards for physicians, chiropractors, and acupuncturists, the office of Self Insurance Plans within the Division of Workers Compensation are also data sources. However none of these data sources have any intrinsic indication of fraud.

pp. 27[1] There is no law enforcement agency in the world that has been able to accurately create a process that will provide the assurances the audit requests; "that the assessed funds are being effectively used".

pp. 28[1] and 29[1] It is impossible to fully and accurately measure the extent and the nature all of fraud in the workers' compensation system. Many of the findings and recommendations within the audit are based on the premise that it is possible to measure the amount of fraud in the workers compensation system. The changing nature of fraud also compounds the problem of measuring fraud. The audit does not tell us how can we "adequately measure and monitor the extent and nature of fraud in the workers compensation system". There is no police department, no state police agency or any public safety organization that has been able to accurately determine the true extent of fraud or crime.

[1] The page numbers cited in this reponse correspond to the redacted copy of the report provided to the fraud commission chairman for his comments. The page numbers do not, however, correspond to the report sections he references in our final report when formatted for publication.

pp. 30[1] Malcom Sparrow's point about focusing resources is correct, but he also stated that it is not possible to accurately measure the true level of fraud. Crime is a subrosa event where the only statistics, are those which are reported by the law enforcement agencies. Crime never uncovered or reported is impossible to measure.

Criminal behavior by its nature constantly evolves towards the path of least resistance.

pp. 30[1] There is a difference between fraud and abuse of the system. This is one reason for the difference of opinion concerning the extent of fraud in the system. The system allows employees to regularly return to work with disability and claim a new injury for the same symptoms. This is not technically fraud but employers perception of this activity, is that it is fraud.

pp. 30[1] In its funding of the 2002/2003 fiscal year, the Fraud Commission set aside $750,000 for the Division of Workers Compensation to create such a data base. However the money was not spent by the DWC. The Commission had no authority to independently mandate implementation of the database.

In 1993, the employer community funded a database (the WCIS at the DIR) to assist with the detection of fraud. This database is still not operational. The Commission has no authority to mandate the DIR produce the database. The reporting is currently voluntarily with the insurance companies. The suggested data format that is being developed for the WCIS is also not compliant with generally accepted data collection formats and is inconsistent with industry practices. Please see the California State Audit report August 2003 California Workers Compensation Program

pp. 32[1] The IRS has never had a total list of all the people who commit fraud. Many citizens use cash and the income is never reported. If it had a comprehensive list of all the citizens who committed fraud it would be able to stop the problem.

pp. 33[1] The GAO has recognized that given the sophisticated and dynamic nature of health care, fraud detection is not an exact science. No matter how sophisticated the fraud detection techniques used, it is unrealistic to expect to identify all fraud

pp. 34[1] The rating bureau data does not include any self-insured data. Self-insureds account for over 24% of the employees in California. Not all employers and insurance carriers comply with ISO reporting. This results in weaknesses in detecting fraud.

pp. 45[1] Since 1997, the DOI Fraud Division and the Fraud Commission have required County Plans. These are documented needs from the district attorneys concerning their information on the cause of fraud, the extent of the problem in their communities and their plans to fight fraud.

pp. 47[1] The Commission has reported information from the district attorneys that 85% of arrests have resulted in convictions. The chart (figure 6 pp. 47) is incorrect.

Response to Audit Recommendations

1. **Engage the Fraud Division to measure the nature and extent of fraud in the workers compensation system**

The Commission has requested a review of the SFC reporting process and has asked the DOI Fraud Division to promulgate regulations that will encourage the consistent reporting of all suspected fraudulent claims. The Fraud Commission and Insurance Commissioner Garamendi have also supported legislation to provide immunity to all interested parties for reporting suspected fraudulent claims to the Fraud Division.

2. **Re-activating a fraud advisory committee**

The Commission will work closely with Department of Insurance to reactivate a fraud advisory committee.

3. **Based on nature and extent of fraud in the system the Fraud Commission and the Insurance Commissioner should design and implement a strategy to reduce fraud**

At several meetings of the Fraud Commission, the Insurance Commissioner has shared his vision and priorities for fighting fraud. The Commission will work closely with Insurance Commissioner Garamendi to develop an overall strategy to reduce fraud.

4. **Revamp the decision making process to determine the amount of money to be assessed.**

The Commission will continue to make its decisions based on all available information. It will also expand its source of information to include the advisory committee to determine trends of fraud within the industry.

5. **Request an annual proposal from the Fraud Division that outlines its objectives and measurable outcomes linked to objectives from the prior year and its objectives for the ensuing year.**

A preliminary review of the budget was performed in December. A revised business plan with measurable objectives and outcomes has been requested of the Fraud Division in January. The Fraud Division is complying with the requests.

6. **Revamp the reporting of the District Attorneys to better determine the appropriate distribution of the assessed money.**

This has been requested from the Fraud Division.

7. **Develop and implement a process for awarding fraud assessment grants that provides consistency among those making funding recommendations, by incorporating standard decision making criteria and a rating system that supports the funding recommendations.**

Concur with recommendation.

8. **Include in the decision making criteria how well the county district attorneys proposals for using the assessment funds align with the strategy priorities developed by the Fraud Commission and the insurance Commissioner.**

Concur with recommendation.

9. **Document the rationale for how decisions on recommendations for grant awards are made.**

Documentation rationale for the 5% subsequent funding is already used in the distribution process.

10. **Reevaluate the Department of Insurance regulations pertaining to how indirect costs are charged to their fraud assessment grants. Seek changes in the regulations to have all District attorneys disclose their method and for all to follow the same formula.**

The Commission has requested these changes be undertaken immediately.

11. **Base recommendations for grant awards on evaluations of the submitted district attorney plans.**

The Commission has always included in the decision making criteria, the evaluation of submitted district attorney plans, how well the county district attorneys proposals for using the assessment funds align with the strategy priorities developed by the Fraud Commission and Insurance Commissioner. In addition to above, the recommendations for grant awards have included factors such as the cooperation of the district attorney with the Department of Insurance Fraud Division, the frequency of reported fraud, trends in the nature of fraud, development of fraud data, geographic, economic and population within regions and counties.

12. Determine whether the provisions of the Bagley-Keene Open Meeting Act apply to the review panel's meetings. If it does seek a specific exemption for confidential discussions of those portions of the grants that include confidential criminal investigation information.

The Commission has asked for a legal opinion on the application of the Bagley-Keene act on the review panel. The panel will follow the recommendations of the legal opinion.

13. Continue the efforts to establish performance measures that can be used to evaluate the effectiveness of the Fraud Division and the participating district attorneys

The Commission will also request the necessary legislative changes to increase the authority funding and oversight of the DOI Fraud Division to implement necessary changes to continually improve in the fight against fraud in the workers' compensation system.

COMMENTS

California State Auditor's Comments on the Response From the Fraud Assessment Commission

To provide clarity and perspective, we are commenting on the response by the Fraud Assessment Commission (fraud commission) to our audit report. The numbers below correspond to the numbers placed in the margins of the fraud commission's response.

The chairman of the fraud commission (chairman) did not provide his comments and perspective on our findings and recommendations in sufficient time for us to evaluate and comment on them in the text of our report. Although we requested that the chairman provide his perspective on the fraud commission's involvement in the fraud program during the course of our audit work, he failed to respond to most of our requests. Specifically, after we interviewed him on February 5, 2004, to gain his perspective on the fraud commission's and review panel's activities and responsibilities in the program, we repeatedly attempted to obtain his verification that we had accurately presented his viewpoint through e-mails sent on three separate occasions during the first half of February 2004, and we also left at least five unreturned telephone messages during that same period. On February 25th he communicated with us, but he did not provide the confirmation we requested.

Moreover, the chairman did not respond to our request to meet and discuss the results of our audit with him before we sent the draft report for his review and comments. As a result, we were unable to include most of his comments and perspectives in our report.

Although we have not had the opportunity to review the basis for most of the chairman's comments, many of his comments included under the heading "technical corrections" are not germane to our findings and recommendations and, therefore, we do not comment on them. However, we do have comments regarding some of the chairman's statements.

- We provided the chairman a redacted copy of our draft report for his review because the statutes under which we conduct our audits preclude us from sharing the outcomes of our audit work with the general public until we complete our work and release our reports. Because our efforts on this audit involved multiple state entities, we provided a redacted copy to each entity we reviewed, including the fraud commission, that included only the findings and recommendations from the report that related to their respective responsibilities in the statewide fraud reduction efforts.

- The chairman states that we did not acknowledge all of the changes that he and the insurance commissioner have made since being elected. He also states that many of our recommendations are initiatives already underway. We provided both the chairman and the insurance commissioner opportunities to provide their perspectives regarding the program. As for the initiatives the chairman refers to, we saw no evidence of changes or actions beyond what we reported concerning such initiatives.

- The chairman mischaracterizes our report when he asserts that the fundamental theme of the audit is the need to fully identify the extent and nature of fraud in the workers' compensation system, and unless the full nature and extent of fraud is identified it is difficult to focus resources and measure results. We make no mention of the need to fully identify workers' compensation fraud. Rather, on page 53, we recommend that the fraud commission and the insurance commissioner direct the Department of Insurance's Fraud Division (fraud division) to measure the nature and extent of fraud in the workers' compensation system and analyze available data from insurers and state departments engaged in employment-related activities to establish benchmarks to gauge the effectiveness of future antifraud activities.

- The chairman incorrectly asserts that the data sources to identify fraud that we recommend in our audit contain no specific fraud identifiers. On page 53, we recommend that the fraud division use data from insurers' paid claims databases and state departments engaged in employment-related activities to measure the extent and nature of fraud in the workers' compensation system and establish benchmarks to gauge the effectiveness of future antifraud activities. The chairman's assertion that these sources contain no specific fraud identifiers undercuts the basic premise of the Workers' Compensation Insurance Fraud Reporting Act, specifically, Section 1877, et seq. of the Insurance Code, which

requires insurers to report suspected fraudulent acts relating to workers' compensation insurance claims. Moreover, in March 2002 the fraud division issued its publication, *Workers' Compensation Insurance Special Investigations Unit Guidelines and Protocols*, to aid insurers in identifying suspicious claims and the elements of fraud in their antifraud efforts. The publication was developed by a volunteer group that included a member of the fraud commission.

- The audit report does contain recommendations that address the problems surrounding insurers' referrals of suspected fraudulent claims to the fraud division. However, because this subject area is the responsibility of the insurance commissioner, not the fraud commission, we did not provide the chairman the sections of the report that contain the findings and recommendations related to fraud reporting.

- We are concerned by the chairman's statement that: "There is no law enforcement agency in the world that has been able to accurately create a process that will provide the assurances the audit requests; "that the assessed funds are being effectively used."" When the Legislature and the governor enacted the workers' compensation antifraud program contained in the Insurance Code, Section 1872.83, they authorized an assessment on the State's employers to pay for enhanced investigation and prosecution of workers' compensation fraud and created the fraud commission to, in conjunction with the insurance commissioner and the fraud division, determine the amount to levy from employers each year and to determine the most effective distribution of the assessment funds to combat fraud. The chairman's statement seems to imply that he does not believe that under the fraud program the fraud commission, insurance commissioner, and the fraud division, can ensure that the funds the fraud commission authorizes to be provided by employers each year are being effectively used to fight fraud. If so, as the chairman of the fraud commission that is accountable to employers for the funds levied against them each year, he should seek the legislative, regulatory, or operational changes necessary to provide that assurance.

- We are surprised at the chairman's apparent reluctance to recognize the importance of measuring fraud in the workers' compensation system. As we state on pages 27 and 28, according to the Coalition Against Insurance Fraud (coalition), the rationale for the consistent measurement of fraud is that you need to know the extent of the problem to effectively solve it. The coalition also made the point that measurement is needed to gain

credibility through convincing consumers and legislators that fraud is a problem that requires remedy. Moreover, we do not suggest that all fraud can be exactly measured. However, using the methods we suggest on pages 30 and 31 on a consistent basis would allow reasonable projections to be made of the amounts of certain types of fraud.

- As we mention on pages 28 and 29, the Internal Revenue Service has a challenge similar to the one faced by the fraud division with workers' compensation insurance, in that it cannot know the exact extent of noncompliance or fraud in the income tax collection system, but it has used audits of statistically selected tax returns to gain insight about the level of taxpayers' overall compliance with tax laws, to understand the effectiveness of its regulations and programs, and to design a strategy for enforcement audits that will best use its limited resources by targeting those returns most likely to be noncompliant.

- These statements by the chairman are confusing. Nowhere on page 30, the page of the report he cites, do we discuss data maintained by the Workers' Compensation Insurance Rating Bureau (rating bureau).

- The chairman makes reference to county plans in his comment regarding the fraud commission's determination of the annual aggregate assessment. However, he misses the point of the section of the report. The plans county district attorneys submit are part of the grant application package and are not available to the fraud commission when it makes its annual determination of the aggregate fraud assessment to be levied against the State's employers. Rather, as we discuss on page 41, at the time the fraud commission makes its determination of the aggregate annual assessment, the only information it has are the proposed budgets that the county district attorneys are asked to provide. These proposed budgets include only a summary of personnel costs, operating costs, and equipment costs, and an outline of the activities to be undertaken by the district attorney. They do not include the numbers of cases the district attorneys plan to prosecute or how many and what type of other activities are planned using grant funds. Moreover, as we mention on page 38, one of the members of the fraud commission stated at the fraud commission's December 2003 hearing that she was concerned that the fraud commission was voting on the fraud assessment amount for fiscal year 2004–05 without having enough information to make an informed decision.

- Figure 6 on page 40 was prepared using information from the fraud division's annual program reports.

- The chairman's response does not adequately address this set of recommendations.

- The chairman's statements are misleading. As we state on page 44, the process used to evaluate the county plans submitted by district attorneys is based on the individual judgments of the members of the review panel using their own personnel criteria without documenting the reasons for their decisions.

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Agency's comments provided as text only.

California Labor and Workforce Development Agency
Victoria L. Bradshaw, Acting Secretary
801 K Street, Suite 2101
Sacramento, CA 95814

April 13, 2004

Elaine Howle*
555 Capitol Mall
Sacramento, CA 95814

Dear Ms. Howle:

This is in response to the Bureau of State Audit (BSA) draft report titled "Workers' Compensation Fraud: Detection and Prevention Efforts Are Poorly Planned and Lack Accountability", which was sent to the Labor and Workforce Development Agency and the Department of Industrial Relations on April 7, 2004.

The findings by the BSA, indicate that improvement is needed in sharing information between State departments to identify potential workers' compensation fraud, that the Department of Industrial Relations has yet to implement required programs designed to identify, report, and deter workers' compensation fraud, and that the Department of Industrial Relations over collects and overcharges fraud assessments from insured employers.

The Department of Industrial Relations has reviewed the findings of the BSA on this subject, and welcomes the opportunity to provide additional and clarifying information regarding its labor standards enforcement and workers' compensation programs and the current efforts they undertake to detect and prevent workers' compensation fraud.

(1) Page 22† "Improvement is needed in sharing information between State departments to identify potential workers' compensation fraud."
(2) Page 25† "The Division of Labor Standards Enforcement has not implemented a program designed to identify employers that illegally fail to provide workers' compensation insurance."

The Department of Industrial Relations agrees, but wishes to provide additional information on the work the Division of Labor Standards Enforcement currently undertakes to identify employers who are not in compliance.

The Division of Labor Standards Enforcement (DLSE) within the Department of Industrial Relations (DIR) has been delegated the responsibility for enforcing the State's mandatory workers' compensation insurance requirements. The Division performs this function through two primary means.

* California State Auditor's comments begin on page 155.

† The page numbers the Labor and Workforce Development Agency cites in this reponse correspond to the sections it references from the redacted copy of the report that we provided for comment. However, the page numbers do not correspond to those sections in our final report formatted for publication.

First, DLSE operates a Bureau of Field Enforcement, which is its proactive enforcement branch responsible for conducting onsite inspections of employers' places of business to determine compliance with labor laws under its jurisdiction. Each of the inspections conducted by DLSE staff includes a determination as to whether the employer has obtained valid workers' compensation insurance coverage or is legally self-insured. When DLSE finds an employer that is illegally uninsured, its staff issues a civil monetary penalty and a stop notice prohibiting the use of employee labor until insurance is obtained. It should be noted that in calendar year 2003, DLSE conducted 6816 inspections and issued 1290 citations to employers for failure to provide proof of insurance coverage.

DLSE also operates a Wage Claim Adjudication unit that processes individual claims for wages from workers who have been underpaid or not paid wages earned. On each of the approximately 60,000 claims filed each year, DLSE sends the employer a request for verification of workers' compensation insurance. If the employer fails to return the requested information and is insured, a penalty in the amount of $500 may be imposed. If the employer returns the information and identifies the insurance carrier along with the policy number and expiration date, the information is filed and no further action is taken. If the employer fails to return the requested information, and it is not obtained through other means, a referral to the Bureau of Field Enforcement is made requesting that an onsite inspection be conducted to determine compliance.

Once a citation is issued to an employer, DLSE attempts to gain compliance. Generally, voluntary compliance is obtained through the employer's securing of the coverage through an insurance carrier. Once coverage is obtained, the DLSE then takes the necessary steps to collect the civil penalty imposed for the violation.

If the employer does not voluntarily comply with the requirement to obtain insurance coverage, DLSE will prepare a referral to the local district attorney's office for filing of a misdemeanor violation for failure to carry the mandatory insurance. In addition, DLSE may also request its legal staff to file for injunctive relief with the appropriate court to force the employer into compliance and stop the use of employee labor until the coverage is obtained.

A cited employer may discontinue business or may reopen using another name or legal entity thereby shielding it from collection of any civil penalties assessed. The fact that it cannot operate using employee labor without coverage, however, stops the violation for non-insurance. It does not, however, allow the employer to open a similar business without the benefit of insurance coverage and DLSE would take enforcement action against the new business entity.

DLSE is aggressively investigating the uninsured employer by determining compliance during every inspection conducted and contact with employers through our wage claim adjudication process. Each year DLSE develops an enforcement plan for the Bureau of Field Enforcement that identifies priorities for investigations that ensure available resources will be concentrated in industries, occupations and areas in which employees are relatively low paid and unskilled and have a history of violations, concentrating on those industries with high rates of noncompliance with workers' compensation insurance requirements. While the DLSE believes that the targeted program would augment their efforts, the program cannot be implemented without the necessary funding.

DLSE does not currently have a centralized database, but operates approximately 18 different databases making the tracking of information including repeat offenders extremely difficult. However, DLSE is in the process of completing a Request for Proposal (RFP) and plans to computerize its many functions and centralize its database in order to increase its enforcement capabilities. The resulting system will allow DLSE to track repeat offenders, exchange relevant case information with other regulatory and enforcement agencies to enhance their effectiveness, facilitate the ability to share data and/or transfer cases, allow investigators remote access to information, and provide the ability to track case information. This will allow the division to better meet its mandates and increase its efficiency.

DIR agrees with the BSA recommendation to report to the Fraud Division those employers that repeatedly fail to provide workers' compensation insurance or benefits. Past attempts at referrals left DLSE with the understanding that the Department of Insurance, (DOI) Fraud Division, is primarily focused on insurers who are under-reporting their payroll or under-reporting injuries to avoid premium costs rather than the uninsured employer. DLSE's focus is on finding and reducing the number of uninsured employers operating. However, DLSE will work with the DOI's Fraud Division to determine whether the information on cited employers would be valuable to them, and if so, DLSE will provide the information.

DIR also agrees with the recommendation that it establish a program that uses data from the Uninsured Employers Fund (UEF), the Employment Development Department (EDD), and the Workers' Compensation Insurance Rating Bureau (rating bureau). However, both the EDD and the rating bureau have indicated that they cannot provide the requested information to DLSE without reimbursement for their costs, estimated to be $182,000 per fiscal year. DLSE, Agency, EDD and DOI are currently meeting to determine what information on employers would be valuable to each and are drafting a memorandum of understanding so that this data may be shared. It should be noted that the Division of Workers' Compensation recently submitted a Feasibility Study Report (FSR) to address and correct limitations in its electronic data management system. The project, as proposed, will support and enhance enforcement against uninsured employers', provide an interface with the Division of Labor Standards Enforcement, and improve enforcement, training and research activities.

(3) Page 26† "The Division of Workers Compensation Has Not Implemented a Protocol for Reporting Potential Workers' Compensation Fraud"

The Department, Agency and the Department of Finance have in place an active plan to remedy this situation in operation, and DIR believes it will be brought to a successful conclusion by the time 60-day follow-up reports are to be delivered.

(4) Page 28† "THE DEPARTMENT OF INDUSTRIAL RELATIONS OVER COLLECTS FRAUD ASSESSMENTS FOR INSURED EMPLOYERS FRAUD ASSESSMENTS FROM INSURED EMPLOYERS"

DIR agrees with the observation that there is wide variation in assessed amounts, and accepts the recommendation to work with the rating bureau to improve the accuracy of the current year premiums used to calculate the fraud assessment surcharge ratio, especially in years of volatile premium changes[1]. However the statement that the rating bureaus estimates result in over collections is misleading. The assessment process *estimates* the workers' compensation premium in one calendar year (CY) then uses that to create a factor for insurers to charge employers in the policies written in the next CY. It then reconciles *actual premium – after the fact*.

The first notice sent to insurers is for an advance fraud assessment based on the rating bureau's estimate of premium. At the time of the second half notice, insurers are provided with a reconciliation worksheet, to reconcile the advance they paid two years prior with the amounts they billed their insured employers. When an insurer has increased market share (written more policies) in the year the surcharge is applied, many more employers will be paying--- resulting in excess collections (but not overcharging of any employer).

The vehicle is designed to be revenue neutral to insurers over the years in collecting the surcharge from insured employers. When an insurer has over paid (i.e. actually collects less than the surcharge they paid in a year) it receives a credit on future years' surcharges, not a refund. This process results in the fund always having a slight surplus, except for years of severely declining premium. Collections in excess of the amount surcharged are kept in the fund, but there are not refunds for collections less than the surcharge, only a credit on all future years billings. The formula for collection was developed with the rating bureau, and was last amended in 2000 to make the approximation to premium reality somewhat more accurate.

(5) Page 32† "Industrial Relations Does Not Ensure that Insurers Correctly Report All Fraud Assessment Surcharges"

The reconciliation between estimated and actual premium addresses this issue, and requires the insurers to submit their actual premium report as a certification. If this is what the draft report means by "verification," it has been in place as a process since the original mechanism (form last revised in 2003).

[1] In the years in question, the premium measured for the assessment varied between a high of 21 billion to a low of 6 billion. Thus it is not surprising that a system which relies on initial estimates from carriers of premium they will write, and later corrects for what they do write, will have variations as high as 51%. Employers change carriers; Carriers terminate employers; Significant numbers of carriers became insolvent; others withdrew from markets.

Department of Insurance premium tax and CIGA assessments are based on the same premium data reports, as are reports to securities regulators (which in turn are governed by federal criminal law, most notably the new Sarbanes-Oxley of 2002 requirement for executive certification.) If there is evidence of substantial misstatements of premium, the issue would be far more serious than simply the fraud assessment, and a criminal prosecution referral to the Department of Insurance Fraud Unit should be made .

Thank you for the opportunity to review and respond to your report on workers' compensation fraud. It provides us with an intelligent, independent, and unbiased assessment of this issue. If you have any questions regarding this response, please contact Marisa Duek, Associate Secretary of Fiscal Policy and Administration or myself at 916-327-9064. Thank you.

Sincerely,

(Signed by: Victoria L. Bradshaw)

Victoria L. Bradshaw
Acting Secretary

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COMMENTS

California State Auditor's Comments on the Response From the Labor and Workforce Development Agency

To provide clarity and perspective, we are commenting on the response by the Labor and Workforce Development Agency (Labor Agency) to our report. The numbers below correspond to the numbers placed in the margins of the Labor Agency's response.

1. The Labor Agency is incorrect when it asserts that our statement that the ratings bureau's estimates result in overcollections of the fraud assessment surcharge is misleading. Simply put, the aggregate fraud assessment to be collected each year is charged to each insurer by dividing the amount of the aggregate assessment by the estimated premiums for the current year, resulting in a surcharge factor, and applying that quotient to each insurers' estimated premium income for the current year. Insurers advance their portion of the aggregate assessment to the Department Industrial Relations (Industrial Relations) and bill their insured employers to recoup the advance. As such, estimates of current year premiums that are too low result in a surcharge factor that is too high and, when applied to actual premiums, further results in total collections that exceed the targeted collection amount. As we discuss on page 101 Industrial Relations regulations require that it use the Workers' Compensation Insurance Rating Bureau's (rating bureau) projection of current year premiums, in part, to calculate the fraud assessment surcharge. As we discuss on pages 99 through 102, recent years' estimates of current year premiums have been too low, resulting in overcollections of the fraud assessment surcharge from employers, and in 1994 and 1995 the estimated premiums were as much as 51 percent too high. Although Industrial Relations notes that increased market share can be a source of excess collections, that is just one of the factors, such as those factors the Labor Agency mentions in its footnote on page 4 of its response (page 152 of our report), to be considered when estimating total current year premiums. Nonetheless, we are pleased that the Labor Agency agrees with our observation that there is a wide variation in assessed amounts

and accepts our recommendation to work with the rating bureau to improve the accuracy of the projected current year premiums used to calculate the fraud assessment surcharge.

- The Labor Agency is technically correct when it states that Industrial Relations credits the excess amount that insurers advance for the fraud assessment surcharge to their future year's surcharges, rather than refund the excess advances to the insurers. As a result, we changed the text of our report. However, we disagree with the Labor Agency's characterization that the process results in its fund always having a "slight surplus" in collections, except for years of severely declining premium. As we report on pages 99 through 101, for its collection of the fiscal year 2003–04 fraud assessment from insured employers—a year in which the targeted collection amount was slightly more than $24 million—Industrial Relations applied a $7 million credit to insurers for over advances in prior years and applied a $16 million credit to amounts to be collected from insured employers to make up for overcollections of the fraud assessment surcharge from insured employers in prior years. In fiscal year 2002–03, Industrial Relations had accumulated $10 million of excess fraud assessment surcharges that it had collected in prior years.

- The Labor Agency misses the point of our finding when it states that reconciling estimated premiums to actual premiums addresses the issue, and its following discussion of premium tax and assessments is not relevant to our finding. As we discuss on page 102, our finding is based on suspicions that Industrial Relations' staff have that some insurers may not be reporting and remitting all of the fraud assessment surcharge they collect from insured employers, an amount its staff estimates ranges from $8 million to $13 million during 1999 through 2001. Industrial Relations does not believe it has the statutory authority to verify the accuracy of the insurers' reconciliation statements.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State
Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press

California State Auditor

BUREAU OF STATE AUDITS

Workers' Compensation Fraud:

Detection and Prevention Efforts Are Poorly Planned and Lack Accountability

Presentation by

California State Auditor

Labor and Industrial Relations

May 12, 2004

This presentation document is only intended to outline selected portions of Report 2002-018, *Workers' Compensation Fraud: Detection and Prevention Efforts Are Poorly Planned and Lack Accountability* (April 2004). For a more complete explanation of the points outlined in this document, refer to the report.

CONTENTS

Audit Scope ***1***

Background Information

Audit Highlights ***2***

Workers' Compensation Antifraud Efforts Lack Adequate Planning and Coordination, and Funding Is Not Determined Using Established Priorities 4

Lacking Adequate Strategic Planning the Fraud Division Has not Met All Its Responsibilities for the Workers' Compensation Antifraud Program 9

Efforts to Detect and Prevent Workers' Compensation Fraud Are Inadequate and Lack Cooperation Between Agencies 16

Key Recommendations ***22***

AUDIT SCOPE

BACKGROUND INFORMATION

Section 1872.83 of the Insurance Code requires the Bureau of State Audits to evaluate the effectiveness of the efforts of the fraud commission, the fraud division, the Department of Insurance, and the Department of Industrial Relations as well as local law enforcement agencies, including district attorneys, in identifying, investigating, and prosecuting workers' compensation fraud and employers' willful failure to secure workers' compensation benefits for their employees.

AUDIT HIGHLIGHTS

FRAUD COMMISSION AND INSURANCE COMMISSIONER

The Fraud Assessment Commission (fraud commission) and the insurance commissioner have not adequately implemented a strategy to ensure that funds assessed against employers—averaging approximately $30 million for each of the past five years—are required and are used in the most effective manner to reduce the costs that fraud adds to the workers' compensation system.

The fraud commission and the insurance commission have not taken the steps necessary to measure the type and extent of fraud in the system or develop a statewide strategy to reduce it.

Shortcomings also exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud.

DEPARTMENT OF INSURANCE FRAUD DIVISION

Both the fraud division and the review panel (comprising fraud commission members, representatives of the fraud division, the Department of Industrial Relations, and an independent criminal expert) fail to consistently apply criteria or document the rationale they use in making funding recommendations for grant awards.

Controls intended to restrict how county district attorneys use their grants of fraud assessment funds to pay for indirect costs are not always effective.

Because the fraud division has not conducted adequate strategic planning, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys.

Lacking a sound strategic plan, the fraud division dedicates too few of its workers' compensation fraud resources to the noninvestigative activities that its statutory responsibilities demand.

The fraud division could manage its investigative efforts more effectively. For example, during the period we reviewed, 87 percent of the referrals of suspected workers' compensation fraud the division received did not end up in the hands of district attorneys for prosecution.

Because the reporting requirements established by the Department of Insurance are ambiguous, independent audit reports submitted by county district attorneys participating in the antifraud program do not assure the fraud division that the district attorneys use grants of fraud assessment funds appropriately.

The fraud division does not offer insurers an effective system for referring suspected workers' compensation fraud to the fraud division. In fact, some of the larger insurers in the workers' compensation system reported no suspected fraud referrals in 2001 and 2002.

The fraud division's special investigative audit unit does not have a program that effectively targets insurers to achieve maximum compliance with suspected fraud reporting requirements. The unit also lacks a standardized approach to conducting audits, issuing timely reports and conducting follow-up, and providing effective penalties to promote compliance.

DEPARTMENT OF INDUSTRIAL RELATIONS

The Division of Labor Standards Enforcement (DLSE) does not routinely refer its findings of employers failing to provide workers' compensation insurance and benefits to employees to the fraud division for consideration of possible criminal prosecution. During 2003, the DLSE cited nearly 1,300 employers for failing to provide workers' compensation insurance and benefits for their employees. Sharing this information could help the fraud division identify potential workers' compensation fraud.

The Department of Industrial Relations has not implemented three mandated programs that would enhance efforts to identify and prevent workers' compensation fraud. State law requires the Department of Industrial Relations to:

- Establish a program to identify employers that fail to secure workers' compensation insurance for their employees.
- Implement a protocol for reporting suspected medical provider fraud.
- Implement a program to annually warn employers, claims adjusters, administrators, medical providers, and attorneys who participate in the workers' compensation system against committing workers' compensation fraud.

The formulas the Department of Industrial Relations uses to calculate the workers' compensation fraud assessment surcharge rates have, in recent years, consistently resulted in insured employers being overcharged. In addition, the Department of Industrial Relations suspects that not all insurers correctly report and remit all the workers' compensation fraud assessment surcharges they collect from employers.

Workers' Compensation Antifraud Efforts Lack Adequate Planning and Coordination, and Funding Is Not Determined Using Established Priorities

THE FRAUD COMMISSION AND THE INSURANCE COMMISSIONER CANNOT BE CERTAIN THAT FRAUD ASSESSMENT FUNDS ARE EFFECTIVELY USED TO REDUCE FRAUD

The Extent and Nature of Fraud Within the Workers' Compensation System Is Not Adequately Measured or Monitored.

Neither the fraud commission nor the insurance commissioner has made a meaningful attempt to measure how much and what types of fraud exist in the workers' compensation system.

Professionals who study fraud maintain that a systematic measurement of fraud is paramount to identifying the appropriate approach to controlling a fraud problem.

Other Entities Have Devised Ways to Measure Fraud and Noncompliance

The Internal Revenue Service (IRS) has used audits of statistically selected tax returns to gain insight about the level of taxpayers' overall compliance with tax laws, and to design a strategy for enforcement audits that target the returns most likely to be noncompliant, thereby, putting the IRS's limited resources to their best use.

Likewise, Medicare fraud experts cite a review of medical payment transactions as an effective tool in identifying the extent and nature of fraud.

The Fraud Division Has Access to Data That Could Help It Assess the Extent of Workers' Compensation Fraud

The fraud division and the insurance commissioner believe fraud committed by medical care providers and employers is more costly to the workers' compensation system and thus have assigned these types of fraud a higher priority in antifraud efforts.

However, without a systematic measurement of the types of fraud and their magnitude, it is difficult to justify not only current activities but also any shift in focus.

The fraud division could perform a statistically valid analysis to detect potential provider and claimant fraud in the form of indicators of actual or potential fraud for a large percentage of the State's workers' compensation insurance market using the data from as few as 37 insurers.

> In 2002, 37 insurers accounted for more than 84 percent of the California workers' compensation insurance market.

No Overall Strategy Exists to Direct Statewide Workers' Compensation Antifraud Efforts

The fraud commission and the insurance commissioner have not collaborated to develop a statewide strategy for reducing fraud in the workers' compensation system.

An expert on fraud and fraud control has identified a fraud control model that includes certain components:

- Commitment to routine, systematic measurement.
- Resource allocation for controls based on an assessment of the seriousness of the problem.
- Clear designation of responsibility for fraud control.
- Deliberate focus on early detection of new types of fraud.
- Fraud-specific controls that intervene before payments are made.

The insurance commissioner's priorities for the fraud program are influenced by stakeholder input and are established with the intent of dedicating resources to high-impact cases, because these cases typically result in higher amounts of fraudulent activity, affect more people, and serve as a larger deterrent to future fraud when successfully prosecuted.

The fraud division's practice of collecting and publishing discrete statistics of investigations and arrests, convictions, and restitution as measures of success of the program's efforts show only that some source of fraud may have been removed from the system, but does not reveal whether the antifraud efforts have actually reduced the overall cost that fraud adds to the system.

The fraud commission and the insurance commissioner have thus far not collaborated in developing a statewide strategy in the form of a plan containing their consensus of the goals, objectives, actions, and performance targets necessary to reduce fraud in the workers' compensation system.

The Fraud Commission and the Insurance Commissioner Conduct Activities to Obtain Input From the Workers' Compensation Community

On several occasions, the fraud commission and the insurance commissioner, sometimes working with the fraud division, have held forums that allowed for stakeholder input on fraud in the workers' compensation system.

In November 2003, the California District Attorneys Association and the Department of Insurance held a roundtable discussion at which they met with members of the fraud commission to inform and educate them on issues related to workers' compensation fraud.

A Workers' Compensation Fraud Advisory Committee exists; however, it has not met since October 2002 because of low attendance at committee hearings, budget limitations, and management changes at the Department of Insurance.

Once elected, the insurance commissioner did assemble one advisory panel and one task force on a temporary basis to provide input on the status of various issues surrounding the workers' compensation system, including fraud. However, the advisory panel's report to the insurance commissioner, issued in February 2003, did not address fraud.

In his February 2004 plan for workers' compensation reform, the insurance commissioner stated that the Department of Insurance is restructuring its fraud and investigative units to improve coordination efforts and prioritize cases of fraud in the workers' compensation system.

ANNUAL FUNDING LEVELS FOR ANTIFRAUD EFFORTS ARE NOT BASED ON DOCUMENTED NEEDS

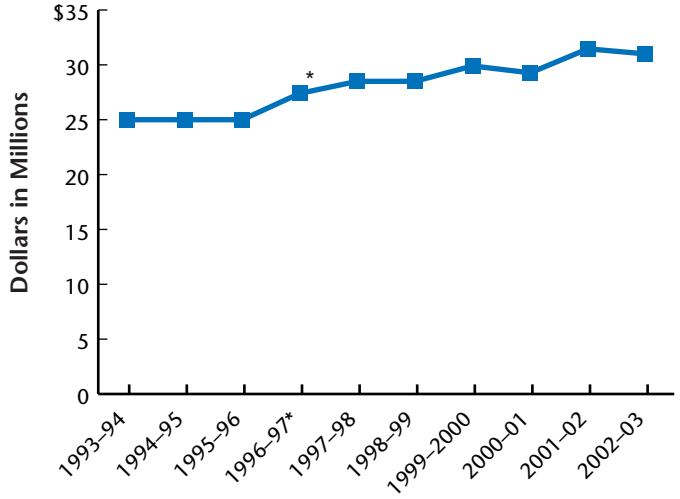
The fraud commission reaches its funding decisions without adequate knowledge of the extent and nature of the problems caused by fraud in the workers' compensation system or the effects of prior years' efforts to reduce fraud.

There is little assurance that the funds it assesses against California's employers—averaging approximately $30 million for each of the past five years—have been used effectively to reduce the amount of fraud and thereby the overall cost that fraud adds to the system.

The Fraud Assessment Commission Bases the Annual Assessment on Previous Funding Levels to Ensure Continuity of the Program

FIGURE 5

Annual Aggregate Assessment Amount Levied by the Fraud Commission



Source: Fraud division's Annual Program Reports.

* Amount includes $2.4 million in restitution funds directed to district attorneys.

The Fraud Assessment Commission Has Limited Information When Determining the Annual Aggregate Assessment

The fraud commission determines the aggregate assessment amount without reviewing any detailed information about the district attorneys' past performance in reducing fraud and without obtaining a specific proposal from the fraud division as to how it plans to spend the grant award during the upcoming year.

The district attorneys' reports outlining activities they completed with the prior year's funding are not required until January, nearly one month after the fraud commission has made its determination.

The fraud commission also does not receive adequate information from the fraud division regarding its activities before making a decision regarding what the aggregate fraud assessment should be.

The Fraud Assessment Commission Has Limited Authority to Hold the Fraud Division or District Attorneys Accountable for Their Antifraud Efforts

According to state law, after certain incidental and administrative costs are deducted, at least 40 percent of the annual aggregate assessment must be set aside for grants to district attorneys and 40 percent must be provided to the fraud division.

The fraud commission has discretion over how the remaining 20 percent is divided for the two purposes. Therefore, the fraud commission has little ability to hold the fraud division or district attorneys accountable for how they spend the funds.

PROCEDURES TO DETERMINE THE MOST EFFECTIVE DISTRIBUTION OF FRAUD ASSESSMENT FUNDS LACK ACCOUNTABILITY

Fraud division staff and members of the review panel that are involved in awarding grant funds do not use standard criteria to evaluate applications or document the rationale they use in reaching their respective recommendations for distributing the funds.

None of the criteria used includes measures of performance that would allow the fraud division staff, the review panel, the insurance commissioner, and the fraud commission to make a more informed decision on the most effective distribution of fraud assessment funds, as the law requires.

The fraud division and the review panel do not base their recommendations for the distributions of fraud assessment funds to participating district attorneys exclusively on an evaluation of the district attorneys' applications for the funds, as called for in Department of Insurance regulations.

Apparently, based on legal advice received in the early days of the program, the fraud division believes that the review panel must recommend base allocations as long as the county sends in a completed application within the time limit prescribed.

Controls intended to restrict the use of grant funds for county administrative costs are not always effective.

The programs' regulations do not appear to provide the restrictions on charges of indirect costs that the fraud commission expects.

The district attorney's office in Los Angeles indicated in its fiscal year 2003-04 grant application that it planned to charge its county indirect costs to its grant at a rate of 43 percent of the cost of salaries and wages charged to the program.

Our comparison revealed that the ratio of Los Angeles County's proposed operating expenses to its costs for salaries and wages was roughly twice that of two other high-cost counties—Santa Clara and San Diego.

The Fraud Division Is Developing Performance Measures to Help It Evaluate Its Own Effectiveness and That of the County District Attorneys in Reducing Fraud

The chief of the fraud division stated that the division is working to establish a set of performance metrics to better evaluate the effectiveness of the fraud division and participating district attorneys in reducing the overall cost of workers' compensation fraud.

Lacking Adequate Strategic Planning the Fraud Division Has not Met All Its Responsibilities for the Workers' Compensation Antifraud Program

THE FRAUD DIVISION'S BUSINESS PLAN DOES NOT ADEQUATELY DEFINE ITS RESPONSIBILITIES

Instead of a strategic plan, the fraud division has developed a business plan.

Fraud Division's Mission Statement

To protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud and to reduce the overall incidence of insurance fraud through antifraud outreach to the public, private, and governmental sectors.

Source: Fraud Division Business Plan (revised January 2004).

The fraud division's mission speaks only to investigations, arrests, and outreach and does not include its noninvestigative functions, which are meant to ensure that investigations are carried out effectively and efficiently.

The Fraud Division Has Not Established the Goals and Objectives Necessary to Meet All Its Responsibilities

Neither its goal nor its objectives are specific enough to provide sufficient direction for the fraud division's antifraud efforts.

Goal and Objectives Defined in the Fraud Division's Business Plan

Goal:

- To be the best consumer protection agency in the nation and to enforce workers' compensation fraud laws vigorously, effectively, and fairly.

Objectives directly related to workers' compensation fraud or to fraud in general:

- To reduce overall workers' compensation costs to employers by increasing the investigations of high-impact cases by 10 percent over the prior year.
- To decrease the cost of workers' compensation insurance in California by working with insurance companies to increase the number of insurance fraud referrals to the fraud division by 10 percent.
- To implement a pilot project to improve outreach efforts in the workers' compensation insurance industry by educating the roofing and construction industry on detecting workers' compensation fraud schemes, including premium fraud.
- To ensure that quality cases are assigned and to preclude the creation of a case backlog, the fraud division will increase by 10 percent the number of suspected fraudulent claims reviewed by supervisors for investigation or disposition.

The fraud division acknowledges that some of the external criticisms of the division include that it is not investigating all cases, that case investigations take too long, and that the fraud division does not provide a return on investment.

The business plan is silent regarding how the fraud division can use its special investigative audit unit to improve insurers' compliance with requirements for reporting suspected fraud.

Some of the objectives that the fraud division has included in its business plan for the workers' compensation antifraud program will not necessarily accomplish their stated outcomes even if the objectives are achieved.

The Fraud Division Does Not Allocate Its Resources to Meet Its Responsibilities or Establish Adequate Performance Measures

The fraud division's local assistance unit—the unit responsible for administering various fraud assessment grants to county district attorneys—has such limited resources allocated to it that it uses the fraud division's research specialist to assist in gathering and compiling information.

As a result, the research specialist is not available to conduct the type of research needed to identify the nature and extent of workers' compensation fraud and develop ways to establish baselines that can be used to measure the effectiveness of antifraud efforts.

The fraud division does not adequately measure its effectiveness in reducing fraud or its performance in meeting its goal and objectives.

THE FRAUD DIVISION DOES NOT MEET ALL ITS NONINVESTIGATIVE RESPONSIBILITIES

Not only does the fraud division substantially ignore noninvestigative functions in its business plan, but it also fails to allocate enough resources to these activities to ensure that it at least minimally meets its responsibilities.

The fraud division does not always use its research specialist to study workers' compensation issues and has not gained the capability to conduct the research necessary to measure the extent and nature of workers' compensation fraud, and evaluate the effectiveness of the fraud division's and district attorneys' efforts to deter fraud, and develop the information mandated by law.

Rather than draw on the skills listed in his job description, such as developing databases containing suspected fraud claims, identifying trends in insurance fraud, and designing statistical and survey techniques and training staff in their use, the fraud division's research specialist spends the majority of his time working in a unit that administers local assistance grants.

In March 2004, the fraud division initiated the process of amending an existing consultant contract to begin working on a set of metrics to measure the effect of its antifraud efforts and refine its business plan.

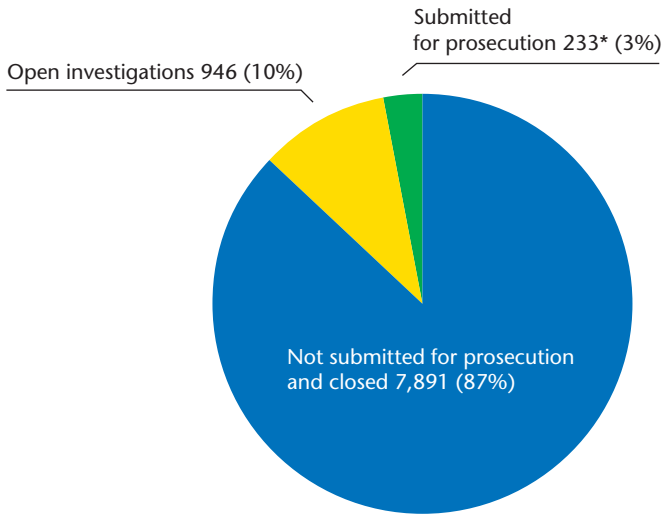
Although by law the annual program reports must contain the funding the fraud division received and a detailed breakdown of how it used the funds, the fraud division ignores these and other requirements and largely limits its reports to the allocations made to the district attorneys, the number of arrests and prosecutions, and the number of convictions and the names of those convicted.

A LARGE PERCENTAGE OF THE FRAUD DIVISION'S REFERRALS DO NOT RESULT IN PROSECUTIONS

Of the workers' compensation referrals the fraud division received between September 2001 and December 2003, 87 percent were not submitted to district attorneys for prosecution, 3 percent were submitted, and 10 percent are open investigations.

FIGURE 7

Outcome of Referrals the Fraud Division Received From September 2001 Through December 2003



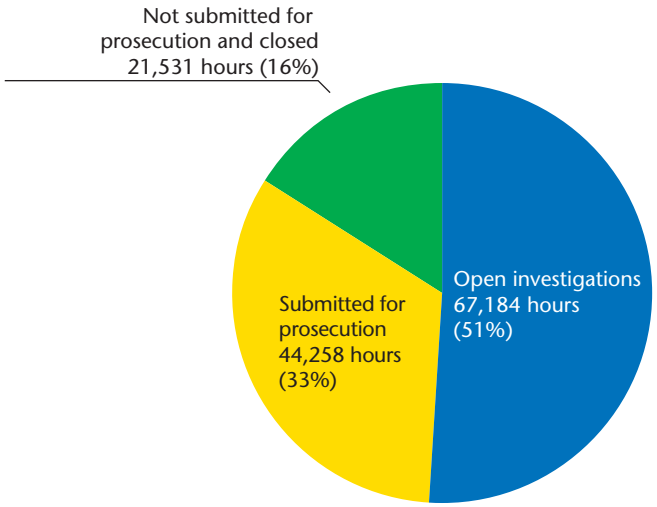
Source: Fraud division's case management database.

* Of the 233 referrals submitted for prosecution as of December 22, 2003, 28 were rejected by district attorneys.

During the same time period, fraud division investigators spent more than 16 percent of their investigative hours on 1,362 cases it closed and did not submit to the district attorneys.

FIGURE 8

Outcome of Hours Fraud Division Investigators Spent on All Referrals From September 2001 Through December 2003


Not submitted for prosecution and closed 21,531 hours (16%)
Open investigations 67,184 hours (51%)
Submitted for prosecution 44,258 hours (33%)

Source: Fraud division's case management database.

Based on the large portion of referrals that the fraud division reports are closed because of insufficient evidence, it appears that the quality of suspected fraud referrals the fraud division receives from insurers is not high enough to allow for successful investigations.

The fraud division's business plan does not address improving the quantity and quality of the evidence the fraud divison receives supporting the referrals.

The fraud division has not adequately monitored and managed its referral and investigation caseloads to determine its success in focusing on the stated priorities of the insurance commissioner and fraud division.

> The fraud division indicates that it emphasizes the insurance commissioner's initiative of focusing on high-impact referrals—those suspected fraud cases that include multiple suspects, involve a medical provider or attorney, or result in large losses—through its referral prioritization system.

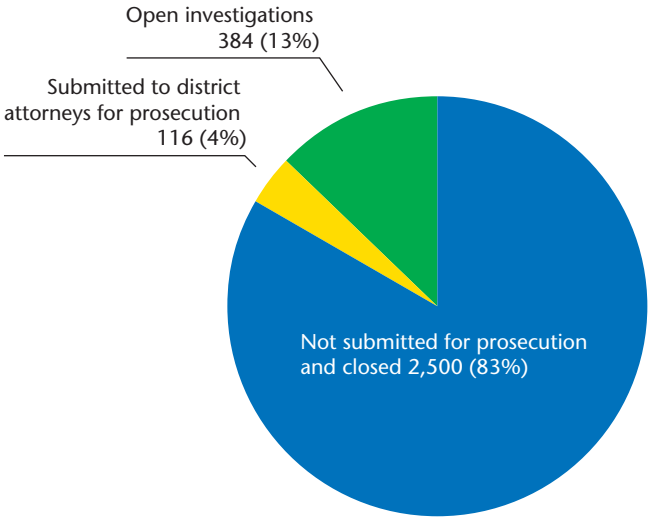
Our review of the case management database shows that between September 2001 and December 2003 half of the cases it submitted to district attorneys were considered high impact. Of the 233 referrals the fraud division submitted to district attorneys, 116 were high impact and 117 were not.

However, because the fraud division did not establish baselines for these types of fraud and set targets for the number of high-impact cases it would submit for prosecution, it cannot know whether these statistics align with the insurance commissioner's initiatives or not.

As shown in Figure 9, of the 3,000 high-impact referrals entered into the database, 2,500 (83 percent) were closed without being submitted to district attorneys for prosecution as opposed to the 116 that were submitted.

FIGURE 9

Outcome of High-Impact Referrals the Fraud Division Received From September 2001 Through December 2003


Open investigations
384 (13%)
Submitted to district attorneys for prosecution
116 (4%)
Not submitted for prosecution and closed 2,500 (83%)

Source: Fraud division's case management database.

The fraud division closes the majority of the high-impact referrals it receives without investigating them.

> Of the 3,000 high-impact referrals received from September 2001 through December 2003, investigators charged hours to only 872, leaving 2,128 with no hours charged. Of those 2,128, 86 are still open and 2,042 were closed without assigning them to an investigator. The reason listed for closing most of these referrals (1,427 or 70 percent) was insufficient evidence.

More than half of the high-impact referrals for which fraud division investigators charged time were closed without being submitted to district attorneys for prosecution.

The Fraud Division Has Not Defined Benchmarks or Targets for Each Appropriate Activity and Used Them to Measure Performance

The fraud division has not come up with a way to measure the return on investment regarding its investigative activities and its success in fighting fraud.

The fraud division has yet to establish a target for how many investigations it plans to submit to the county district attorneys per year and how many of those investigations it expects district attorneys to successfully prosecute each year so that it can measure the success or failure of its investigative efforts funded by the fraud assessment.

The division could measure its return on investment by setting a targeted return on the fraud assessment funds invested in the program compared to the amount of chargeable fraud taken out of the system based on successfully prosecuted cases.

THE DIVISION DOES NOT ADEQUATELY MONITOR THE USE OF FRAUD ASSESSMENT FUNDS AWARDED TO DISTRICT ATTORNEYS

Department of Insurance regulations require that each county submit an annual independent audit certifying that the county district attorney's expenditures complied with the laws, regulations, request for application guidelines, and the county plan.

> Although the request for application guidelines include audit procedures that must be followed, all but one of the audits we reviewed failed to adhere to these procedures.

In fact, 26 of the 27 audits we reviewed did not include the required certification, nor did they comment on the internal control system as it applied to the workers' compensation antifraud program.

These audit reports did not provide an opinion on the district attorneys' compliance with laws, regulations, contracts, and grant provisions. Rather, they performed certain tests to assure that the financial statements were free of material misstatement.

Department of Insurance Audits Provide Limited Assurance That District Attorneys Properly Use Fraud Assessment Funds

Department of Insurance audits of county district attorneys' use of workers' compensation fraud assessment grants give a thorough and documented indication of their compliance with the requirements of the grants. However, the audit unit has only completed a limited number of these audits.

During the last two years, the audit unit has reviewed 13 of the more than 30 county district attorneys that receive workers' compensation fraud assessment grants, reported 38 findings, and recommended that these district attorneys return $103,400 in grant funds because of questionable expenditures.

The audit unit has not recently reviewed 22 of the 34 county district attorneys that received fraud assessment funds in fiscal year 2002-03, and reviews of the five county district attorneys receiving the largest amounts of grant funds have not been conducted since 1998.

The chief of the audit unit told us that he places county district attorneys who receive only workers' compensation grant funds at the bottom of the audit plan, as he receives no funding to conduct these audits. However, if the fraud division required the county district attorneys to submit audit reports that met the requirements in the Department of Insurance regulations and fraud grant application guidelines and contained an opinion on compliance, the audits performed by the audit unit would not be necessary.

Efforts to Detect and Prevent Workers' Compensation Fraud Are Inadequate and Lack Cooperation Between Agencies

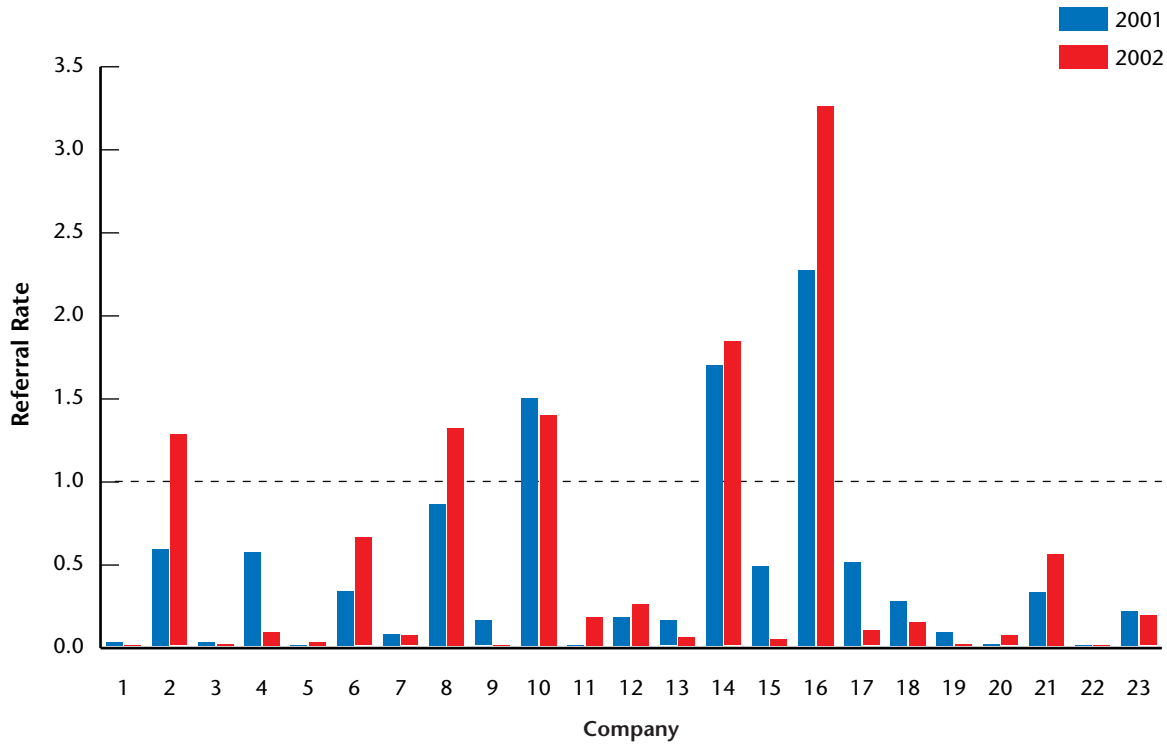
Insurer Compliance With Requirements to Detect and Report Suspected Workers' Compensation Fraud Varies

Despite a requirement that insurers investigate suspected fraud and refer to the fraud division claims that show reasonable evidence of fraud, insurers vary significantly in the number of fraud referrals they submit.

As shown in Figure 13, among insurers earning workers' compensation premiums exceeding $40 million per year, some appear to be underreporting suspected fraud while others appear to be regularly referring suspected fraudulent claims.

FIGURE 13

Referral Rate of Insurers Earning More Than $40 Million in Annual Premiums During 2001 and 2002

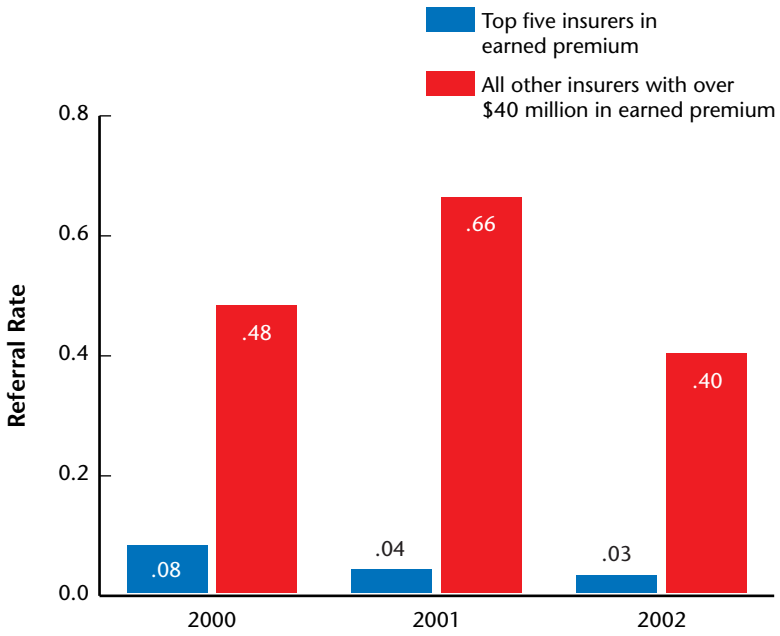


Sources: Department of Insurance Web site and the fraud division's case management database.

Five insurers reporting the highest earned premiums for 2000 through 2002 referred suspected claims at a much lower rate than those reporting lower levels of earned premiums. The referral rate for the top five insurers in 2002 was .03, or less than one suspected fraudulent claim per $20 million in earned premiums.

FIGURE 14

Referral Rates for Workers' Compensation Insurers by Earned Premium for 2000 Through 2002



Sources: Department of Insurance Web site and the fraud division's case management database.

Barriers Exist That Prevent Insurers From Consistently Referring Suspected Fraud

- The lack of a uniform methodology and standards for assessing and reporting suspected fraud is one reason that some insurers may be derelict in their responsibility to fight fraud.

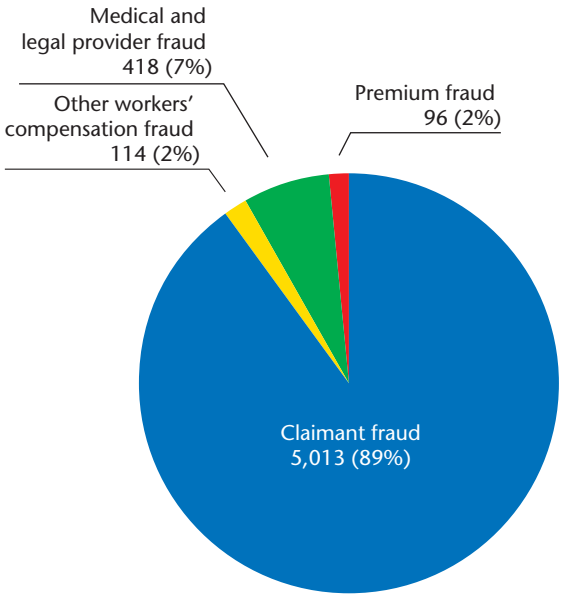
- Past regulations poorly defined when insurers should refer suspected fraud to the fraud division.

- Perceived exposure to civil actions when criminal prosecutions of referrals are not successful.

Insurers are not reporting the types of suspected fraud the insurance commissioner has designated as high-impact. According to our review of its database of fraud referrals, the division received almost two-thirds of its referrals from insurers, and 89 percent of these were for claimant fraud.

FIGURE 15

Types of Suspected Fraud Referrals Insurers Reported From September 2001 Through December 2003



Source: Fraud division's case management database.

Audit Efforts Have Not Provided Adequate Coverage of Insurers

The fraud division's special investigative audit unit has not achieved the most effective audit coverage of the community of workers' compensation insurers.

- The fraud division focused 59 percent of its audits on insurers that represent less than 0.5 percent of the market.

- The special investigative audit unit chose not to review 43 percent of the insurers selling workers' compensation in the State because they do not have offices in California.

- The special investigative audit unit reviews an average of only 14.5 (8 percent) of the 175 insurers in the fraud division's workers' compensation database each year.

The special investigative audit unit has not performed more audits of workers' compensation insurers during the past two years because of inadequate staffing levels and travel restrictions.

The insurance commissioner stated that because the special investigative audit unit is also responsible for auditing insurers selling other lines of insurance it could not focus its resources exclusively on workers' compensation audits.

The Special Investigative Audit Unit Lacks Standards in Its Approach to Auditing Insurers

Without standards for audit objectives, audit procedures, and supervision of the audits, the fraud division cannot be certain that the special investigative audit unit is helping insurers provide referrals of the quality that the fraud division needs to effectively and efficiently investigate workers' compensation fraud.

Not surprisingly, the reviews we examined reflect disparate approaches.

Of the 10 reviews we examined, we found only four in which the reviewers sampled claims and in two of those cases the reviewer allowed the insurer to select the claims for review.

The fraud division is preparing a manual of procedures for conducting reviews, and it has already implemented a policy to use a standard random sampling methodology with a minimum sample of 30 claims per audit.

The Special Investigative Audit Does Not Promptly Finalize Its Reports or Track and Enforce Audit Findings

For five of the seven audits of insurers with findings that we reviewed, the special investigative audit unit had not sent letters to the insurers outlining the findings, even though between one and three months had passed since the review was completed.

The special investigative audit unit also does not adequately track its audit findings to follow up on corrective action by insurers.

The fraud division has not established effective penalties to promote compliance with the requirement that insurers maintain a special investigative unit.

The law states that any insurer failing to comply with fraud-reporting provisions will be subject to a maximum fine of $55,000 and/or suspension of the insurer's certificate of authority to conduct business in the State.

Insurers are not complying with the requirements in law related to special investigative units.

Out of our sample of 10 audit reviews, one insurer did not meet the statutory standards of maintaining a fraud-reporting function, and four had failed to make any referrals of suspected fraud to the fraud division as called for by the law.

IMPROVEMENT IS NEEDED IN SHARING INFORMATION BETWEEN STATE DEPARTMENTS TO IDENTIFY POTENTIAL WORKERS' COMPENSATION FRAUD

The Department of Industrial Relations' DLSE does not share the results of its field reviews of employers with the fraud division.

Without greater sharing of information, the fraud division is denied information that Industrial Relations possesses on employers that fail to provide workers' compensation insurance for their employees.

During 2003, the DLSE conducted 6,816 field reviews and cited nearly 1,300 employers for failing to secure workers' compensation insurance.

The DLSE does not track repeat offenders. As a result, the DLSE denies the fraud division a tool it could use for identifying employers that repeatedly fail to carry workers' compensation insurance, thereby indicating a willful intent that warrants investigation.

INDUSTRIAL RELATIONS HAS YET TO IMPLEMENT REQUIRED PROGRAMS DESIGNED TO DETER WORKERS' COMPENSATION FRAUD

Recent legislation mandates that Industrial Relations implement three antifraud programs:

- A program to detect employers that willfully fail to secure workers' compensation insurance for their employees. (Law required the program to be operational by January 1, 2003.)
- A program establishing a protocol for reporting suspected fraud by medical providers. (Law required the protocols to be operational by January 1, 2004.)
- A program requiring Industrial Relations to issue annual warnings against committing workers' compensation fraud to employers, claims adjusters and administrators, medical providers, and attorneys who participate in the workers' compensation system, and to notify them of the relevant penalties. (Law required the program to be operational by January 1, 2003.)

INDUSTRIAL RELATIONS COLLECTS EXCESS FRAUD ASSESSMENTS FROM INSURED EMPLOYERS

Industrial Relations often collects much more than it intended because the formula it uses to calculate the surcharge rate usually results in overcharges to insured employers.

Industrial Relations' formula for calculating the fraud assessment to be collected from insured employers results in very large variations between the estimated and actual collections.

Each year Industrial Relations estimates and requests an advance payment of the fraud assessment surcharge from insurers that write workers' compensation policies in California, based on the projected policy premiums for the current year.

Insurers collect the surcharge through the premiums they charge employers.

Industrial Relations' regulations require that it use the rating bureau's projection of total current year premiums to determine the fraud surcharge factor. However, information provided by Industrial Relations suggests that the rating bureau does not always provide accurate estimates of current year premiums.

Industrial Relations does not determine that insurers correctly report all fraud assessment surcharges. Industrial Relations staff noted that in prior years, some insurers reported they did not bill their insured employers for fraud surcharges even though the insurers showed premium income in those years.

Some insurers have reported that the amount paid in advance exactly equaled the amount of fraud assessment surcharges they billed to insured employers, a circumstance that is very unlikely.

KEY RECOMMENDATIONS

The fraud commission and the insurance commissioner should direct the fraud division to measure the nature and extent of fraud in the workers' compensation system.

The insurance commissioner should consider reactivating an advisory committee comprising stakeholders focused on reducing fraud in the workers' compensation system to contribute to the data analyses, provide input about the effects of fraud, and suggest priorities for reducing fraud.

The fraud commission and the insurance commissioner and his staff should design and implement a strategy to reduce workers' compensation fraud. The strategy should be systemwide in scope and include goals, objectives, priorities, and the measurable targets that can be effectively communicated to the fraud division and the county district attorneys participating in the antifraud program.

To gather the information it needs to determine the annual amount to assess employers to fight fraud, the fraud commission should:

- Revamp its decision-making process so that it includes the best information available including (1) the results of the Department of Insurance's analyses of the nature and extent of fraud in the system, (2) analysis of the effectiveness of efforts by the fraud division and district attorneys, and (3) any newly emerging trends in fraud schemes that should receive more attention.

- Request an annual report from the fraud division that outlines objectives from the prior year that are linked to measurable outcomes, and its objectives for the ensuing year together with estimates of the expenditures that the fraud division needs to accomplish those objectives.

- Request each county district attorney to submit a report listing the district attorneys' accomplishments in achieving the goals and objectives outlined in the prior year's application and the goals and objectives for the ensuing year.

To better ensure that fraud assessment funds are distributed to district attorneys so as to most effectively investigate and prosecute workers' compensation fraud, the fraud commission and the insurance commissioner should:

- Develop and implement a process for awarding fraud assessment grants that provides for consistency.

- Include in the decision-making criteria how well county district attorneys' proposals for using fraud assessment funds align with the strategy and priorities developed by the fraud commission and the insurance commissioner.

- Document the rationale for making grant award decisions.

- Make recommendations for total grant awards, including the base allocations, on evaluations of county district attorneys' plans that include how they will use the funds, as required by the Department of Insurance regulations.

- Continue current efforts to establish performance measures to use in evaluating the effectiveness of the fraud division and participating district attorneys in reducing workers' compensation fraud.

The fraud division should:

- Conduct the research needed to advise the fraud commission and the insurance commissioner on the optimum aggregate assessment needed annually to fight workers' compensation fraud.

- Modify its business plan to meet noninvestigative responsibilities.

- Establish benchmarks to measure its and the district attorneys' performance in meeting goals and objectives.

- Reevaluate the process it has established for insurers and other state entities involved in employment-related activities to report suspected fraud.

The fraud commission and the insurance commissioner should require the fraud division to conduct a return-on-investment analysis for the workers' compensation antifraud program as a whole and to annually report the results.

To improve the level of assurance contained in the independent audit reports submitted by county district attorneys, the fraud division should:

- Clarify its expectations for the independent audits.

- Ensure that county district attorneys comply with the independent audit requirements and submit their audit reports in a timely manner.

To ensure that it receives the suspected fraud referrals it needs from insurers to efficiently investigate suspected fraud, the fraud division should continue its efforts to remove the barriers that prevent insurers from providing the desired level of referrals.

The fraud division should work with insurers to reduce the number of referrals that are not likely to result in a successful investigation or prosecution, thereby preserving limited resources.

To help the fraud division investigate employers that fail to secure payment for workers' compensation insurance for their employees, the Division of Labor Standards Enforcement

should track employers that do not provide workers' compensation insurance for their employees and report to the fraud division any employer that repeatedly fails to provide workers' compensation insurance.

To ensure that it targets employers in industries with the highest incidence of unlawfully uninsured employers, the Division of Labor Standards Enforcement should establish a program that uses data from the Uninsured Employers Fund, the Employment Development Department, and the rating bureau to target unlawfully uninsured employers, as required by law.

The Division of Workers' Compensation should implement the fraud-reporting protocols required by law.

The Division of Workers' Compensation should warn participants in the workers' compensation system of the penalties of fraud, as required by law.

The Department of Industrial Relations should work with the Workers' Compensation Insurance Rating Bureau to improve the accuracy of the projected premiums for the current year, which it uses to calculate the fraud assessment surcharge to be collected from insured employers.

The Department of Industrial Relations should seek the authority and establish a method to verify that insurers report and submit the fraud assessment surcharges they collect from employers.